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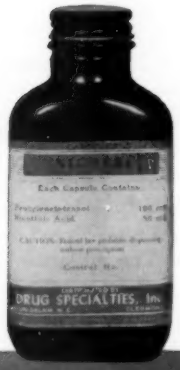

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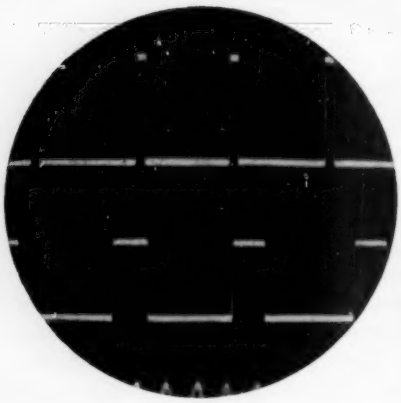

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1. Gerhard Hirschfeld and Joseph Bell *Diseases of the Nervous System* **12**: 3-7, September, 1951.
2. Gerhard Hirschfeld *Journal of Nervous and Mental Diseases* **117**: 323-328, April, 1953.
3. W. T. Liberson *Psychiatric Treatment* Vol. 31 of Proc. A.R.N.M.D. Williams and Wilkins, Baltimore, 1953.

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A STUDY OF PSYCHOTHERAPEUTIC RELATIONSHIPS BETWEEN PHYSICIANS AND SCHIZOPHRENIC PATIENTS

JOHN C. WHITEHORN, M.D., AND BARBARA J. BETZ, M.D.[1, 2]
BALTIMORE, MD.

A major presenting obstacle in the psychotherapy of schizophrenic patients is their characteristic lack of readiness to accept the physician, or any other person, as a working partner in a personal relationship. Schizophrenic illnesses have a marked tendency to chronicity, and it may be that this tendency results from the persistent interpersonal autism which often seems so intractable. In the early years of this century the possibility that schizophrenic patients might actually become engaged in a meaningful personal relationship, with therapeutic benefit, was not widely credited. Much personal experience and observation has brought convincing evidence that the schizophrenic patient is not absolute in his inhospitality to overtures from others. The meaning of the social distance maintained by the schizophrenic patient has become increasingly intelligible as a sensitive interpersonal pattern of separateness, motivated by a fearful and hateful lack of faith in himself and others.

This motivational understanding of the schizophrenic patient's social wariness provides a rational basis for meaningful psychotherapeutic efforts to modify the patient's personal attitudes, in the direction of greater trust and confidence in himself and others. The physician's modes of participation and the patterning of his therapeutic role to effect such attitudinal modification are important matters for clinical inquiry and experimentation.

One natural method for studying this problem is for the psychiatrist, with increasing experience, understanding, and wisdom, to apply himself to the task of individual therapy, in patient after patient, to observe, then, whether the patients seem to gain increasing benefits; and to attempt to analyze these interpersonal transactions to ascertain if possible what has been helpful and what has not been helpful. To a certain extent it is possible for one, in a planned way, to vary somewhat the style and method of attempted psychotherapy; but this experimental method has serious limitations. It is difficult for one physician to plan and maintain crucially different approaches and attitudes and patterns of interaction, for the sake of planned experimentation, because some of the significant variables appear to be manifestations of the physician's own personality characteristics, not readily changed by planned effort.

During the past decade it has been possible for us to organize and carry out a better job in this technically difficult field, by analyzing the differences between different physicians and their different styles of transactions with schizophrenic patients, and by making systematic comparisons designed to reveal the differential effects on patients' progress and outcome.

The purpose of this paper is to report a study of the relationships between patients with a schizophrenic illness and their physicians, and the effects thereof on the patient's clinical progress. The empirical facts which we sought to scrutinize and characterize may be sorted roughly into 4 categories: (1) the types of relationship established by the patients with their physicians; (2) the types of diagnostic perspectives in which the physicians view their patients; (3) the types of strategic goals selected as the primary focus of therapy; and (4) the types of tactical patterns utilized in therapy with the patients. The study was designed to explore these

[1] From the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, this work has been supported in part by funds from the Scottish Rite Committee on Research in Dementia Praecox of the Supreme Council, Thirty-Third Degree Masons, Northern Jurisdiction, administered by the National Association for Mental Health, and in part by the Dr. Mary P. Dole Medical Fellowship of Mount Holyoke College.

[2] The statistical procedures used in this study were carried out in close consultation with David Rosenthal, Ph.D., whose critical interest was of the greatest value and assistance. The help of Mrs. Jean B. Fowler in abstracting the data for an analysis of changes in the patients' Behavior Charts is also acknowledged with appreciation.

clinical phenomena in as factual and objective a way as possible.

For the purposes of this study attention was focussed on the psychotherapeutic relationship of 14 physicians and 100 schizophrenic patients. The physicians were all members of the resident staff of the Henry Phipps Psychiatric Clinic at some time between the years 1944 and 1952. The schizophrenic patients whose relationship to these physicians and whose clinical progress are characterized were all residing in the hospital during their period of teatment. Each patient was treated individually by one of the 14 physicians during the period of hospitalization. The characterizations of the therapists and the patients are based on data recorded in the individual case records by physicians and nurses during the time when treatment was in progress.

THE CASE RECORDS

The empirical facts upon which this study is based have been obtained by analysis of the material in our case records. In addition to the usual historical and clinical data there are 3 sections in each of our records that proved of special usefulness for research purposes. One is a section called the Personal Diagnostic Formulation in which the physician records his diagnostic understanding of the patient's illness and personality problems and states his aim in treatment and his plans for realizing these aims. Another is called Therapy and Progress in Personal Adjustment. This is written at the time of the patient's discharge and is a brief record of what was aimed for in treatment, how treatment was managed, and how the patient progressed. A third useful section of the case records was the Behavior Chart. This is a graphic chart on which the nurses' daily observations of the patient are recorded, supplemented by descriptive notes of the patient's behavior. The items marked on the chart are organized in 4 zones according to whether they characterize normal, overactive, underactive, or "odd" behavior (hallucinations, delusions, mannerisms, etc.). Such charts have been kept in this Clinic since 1914 and have proved realistic, sensitive indicators of changes in the patient's behavior both in favorable and unfavorable directions. Since they are kept by the nurses they provide a second record of changes in the patient's behavior during his period of hospitalization, independent of the physicians' judgments.

THE PHYSICIANS

In selecting the physicians for study in the present investigation 2 criteria were set up. It seemed desirable, first, that the physicians have a comparable amount and range of personal clinical experience; and, second, to select physicians some of whom ranked high and some of whom ranked low in favorable treatment results with schizophrenic patients, with a view to seeing whether differences existed and could be highlighted. A list of physicians was assembled each of whom had treated a minimum of 4 schizophrenic, 4 depressed, and 4 neurotic patients. Thirty-five physicians met this requirement.[8]

The improvement rate for schizophrenic patients achieved by each of the 35 physicians was then calculated by dividing the number of patients discharged improved by the number treated. The 35 physicians were then listed in descending order. The improvement rates were found to range from 100.0% to 0.0%; the average improvement rate was 50.6%. The 7 high-ranking physicians (hereafter referred to as Group A Physicians), with improvement rates ranging between 68.0% and 100.0% (average 75%) and the 7 low-ranking physicians (hereafter referred to as Group B Physicians), with improvement rates ranging from 0.0% to 34.0% (average 26.9%), were then selected for the present study.

SELECTION AND CHARACTERIZATION OF PATIENTS

The schizophrenic patients involved are, of course, the patients of these 14 physicians, who as it happened had treated a total of 103 schizophrenic patients. This number was rounded off to 100 as a statistical convenience, by eliminating 3 who had the shortest hospital record.

Of these 100 patients, 48 were treated by

[8] Actually, these 35 physicians were found to have treated an average of 9 schizophrenic, 13 depressed, and 9 neurotic patients.

the Group A physicians with 36 (75.0%) discharged improved. Fifty-two were treated by the Group B physicians, with 14 (26.9%) discharged improved.

These 100 patients are a particularly suitable sample for studying psychotherapeutic phenomena since only 10 of them received shock therapy. Of the 5 patients who received insulin shock therapy, 1 was discharged improved. Of the 5 patients who received electric shock therapy, 3 were discharged improved. Further studies are planned, by similar methods, on a series of insulin-treated schizophrenic patients, to gain a clearer view of the psychotherapeutic processes involved in their progress and outcome.

Improved and Unimproved Categories of Patients.—Of these 100 patients, 50 were considered "improved" at the time of discharge and 50 "unimproved." What does this mean? In this clinic, the appraisal of the patient's condition at discharge is made not only by the physician who treated the patient, but also by the senior resident psychiatrist and by the psychiatrist-in-chief. Any personal bias of the individual physician is thus, presumably, subject to correction by the clinical judgment of more objective observers. For purposes of a scientific inquiry, however, particularly in a study like the present one where the clinical progress of patients is itself used as a major criterion for evaluating psychotherapeutic processes, objective evidence supporting the validity of the appraisal of the patient's progress is desirable. Such evidence was sought, and is presented in Table 1, in relation to 4 kinds of events which are independent of the physician's subjective impressions. These events are: (1) the disposition of the patient at the time of discharge—whether discharged to the community or transferred to another hospital; (2) increased participation in social relationships with other patients, as recorded in the daily notes kept by the nurses; (3) increased participation in the clinic activity programs, as recorded in nursing and occupational therapy reports; and (4) changes in Behavior Chart markings (Figure 1). The number of markings in each of the 4 behavior zones during the first 10 days after admission and the last 10 days before discharge were counted and the direction of the shift noted.

TABLE 1

EVIDENCE SUPPORTING ACCURACY OF DISCHARGE APPRAISAL OF CONDITION OF PATIENTS AS "IMPROVED" OR "UNIMPROVED"

	Improved (50 patients)	Unimproved (50 patients)
Discharge to community *	45	25
Showed increased participation with other patients *	33	7
Showed increased participation in clinic activity programs *	38	10
	Improved (47 patients)	**Unimproved (43 patients)**
Changes in Behavior Chart markings †		
a. More normal marks ‡	29	14
b. More overactive §	17	23
c. More underactive ‖	14	28
d. More "odd" *	3	20

* Difference significant at .001 level.
† Based on analysis of 90 patients, 47 improved and 43 unimproved.
‡ Difference significant at .02 level.
§ Difference not significant.
‖ Difference significant at .01 level.

These data complement and support the clinical appraisals of the patient's clinical progress.

The quality of improvement made by the 50 patients whose progress was considered favorable may be characterized briefly. Improvement was evaluated under 3 headings: (1) symptom decrease only—21 patients; (2) symptom decrease and increase in social effectiveness only—17 patients; and (3) symptom decrease, insight increase and increase in social effectiveness—12 patients. None of the 50 patients who were considered unimproved fell into any of these 3 categories.

Group A and Group B Categories.—Of the 100 patients studied, 48 were treated by the Group A physicians and 52 by the Group B physicians, with markedly contrasting rates of improvement. Why did 75% of Group A patients improve, whereas only 27% of Group B patients improved? How can this difference be accounted for among physicians whose level of training and clinical experience are so comparable? Three possible explanations suggest themselves and will be weighed in relation to this particular series of 100 patients and their therapists.

1. Were the patients of the Group A phy-

sicians clinically "easier" cases than those of the Group B physicians, with a more favorable prognosis from the start?

This possibility was weighed by comparing the 48 patients treated by the Group A physicians with the 52 patients treated by the Group B physicians in respect of the personal and clinical items listed in Table 2. The incidence of each of these items in the patients treated by the two groups is shown. To the extent that the characteristics selected for comparing these 2 groups are valid for the purpose, the 2 groups appear to have been quite comparable when treatment was begun. The Group B patients had a slightly higher level of education, and also a few more of them manifested hallucinations and mannerisms, but the difference between the 2 groups is not great enough to be of statistical significance.

2. Were the Group A physicians "better therapists" than the Group B physicians, with greater general therapeutic aptitude, so that their patients, regardless of diagnostic category, might be expected to make more favorable clinical progress?

In a larger study of the therapeutic effectiveness of 35 members of our resident staff, we have found that the effectiveness of individual physicians varies according to the

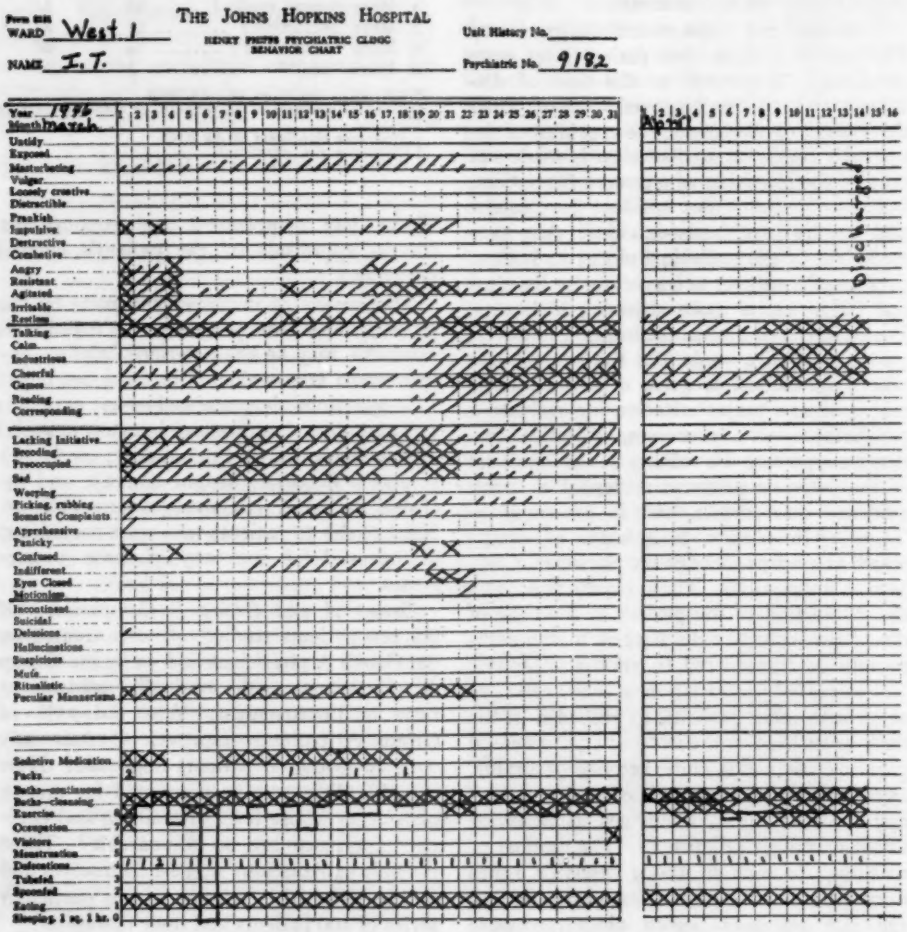

FIG. 1

TABLE 2

COMPARISON OF PERSONAL AND SOCIAL DATA AND OF CLINICAL AND PERSONALITY CHARACTERISTICS OF SCHIZOPHRENIC PATIENTS TREATED BY GROUP A AND GROUP B PHYSICIANS

	Total	Group A physicians (48 patients)	Group B physicians (52 patients)
Personal and social data			
1. Males	45	20	25
2. Age under 30	62	31	31
3. Married	38	19	19
4. High school or more	76	33	43
5. Working until P. I.	70	35	35
Personality characterization			
1. Sensitive	95	46	49
2. Shy	82	38	44
3. Submissive	66	33	33
4. Stubborn	40	19	21
5. Outgoing, lively	39	20	19
6. Eccentric	28	13	15
Clinical characteristics			
1. Does not talk freely	47	22	25
2. Mannerisms	39	14	25
3. Hallucinations	37	14	23
4. Delusions	61	28	33
5. Angry	47	21	26
6. Fearful	53	28	25
Duration of illness under 4 months	36	20	16
Diagnostic subdivision			
1. Undifferentiated	54	24	30
2. Paranoid	22	10	12
3. Paranoid state	9	4	5
4. Catatonic	8	5	3
5. Hebephrenic	2	1	1
6. Other (simple, latent, schizoid)	5	4	1

type of patient. One's improvement rate with schizophrenic patients does not correlate highly with one's improvement rate with depressed or neurotic patients. In particular, the Group A physicians who showed, in comparison with the Group B physicians, nearly 3 times as high an improvement rate in their schizophrenic patients, did not show, in their treatment of depressed or neurotic patients, significantly higher improvement rates than the Group B physicians, and hence their success with schizophrenic patients could not be attributed to greater general therapeutic aptitude.

3. Did the Group A physicians treat their schizophrenic patients in a significantly different way than the Group B physicians? Did these patients' better response to treatment depend upon distinguishable differences in physicians' approach or mode of participation in psychotherapy?

To find reliable empirical answers to these questions constitutes the main effort of this study, and it may be stated that the data provide evidence for affirmative answers to these questions. We sought to check and recheck and to particularize these affirmative answers by appropriate analyses of the facts available in our records.

Abstracting the Case Records to Characterize Physicians' Approach and Patients' Reaction.—A reading of the 100 case records gave an impression of the kinds of pertinent data which one might expect to find consistently recorded. A check list was then prepared to indicate the following phenomena: (1) the type of improvement; (2) the type of relationship which the schizophrenic patient made with the physician; (3) the type of diagnostic perspective with which the physicians viewed the patient; (4) the type of strategic goals selected by the physicians as the primary focus of therapy; and (5) the type of tactical pattern utilized by physicians in actual contacts with the patient. This check list is shown in detail in Table 3. It was filled out for each of the 100 schizophrenic patients by abstracting the appropriate data from the individual case record. It will be noted that Table 3 is divided into 5 major categories. A reliability check was done to determine how reliably the case record material could be categorized under these 5 major headings. A random sample of 10 cases was abstracted and categorized independently by each of the authors. Perfect agreement was reached in categorizing "Outcome" and "Type of Physician's Personal Formulation." Agreement was obtained in 9 out of 10 cases in categorizing "Type of Relationship of Patient to Physician"; in 8 out of 10 cases in categorizing "Type of Tactical Pattern Utilized by Physician"; and in 7 out of 10 cases in categorizing "Type of Strategic Goals Selected by Physician." These findings indicated good reliability. All subsequent statistical comparisons in this paper are based on these major groupings.

In some instances patients had had a

TABLE 3

CHECK LIST FOR CATEGORIZING THE DATA IN THE CASE RECORDS

A. Outcome
- I. Improved ..... II. Unimproved .....
  - 1. Symptom Decrease .....
  - 2. " " + Increase in Social Effectiveness .....
  - 3. " " " " " " " + Insight Increase.....

B. Type of Relationship of Patient to Physician (Check one)
- I. Less Confidential (More autistic)
  - 1. Superficial social .....
  - 2. Passive withholding .....
  - 3. Aggressive rejecting .....
- II. More Confidential (Less autistic)
  - 4. Accepts some support; depends.....
  - 5. Depends and confides.....
  - 6. Depends, confides, and evaluates.....
  - 7. Depends, confides, evaluates with problem solving.....
- III. Other .....
- IV. Data not recorded.....

C. Type of Physicians "Personal Formulation" (Check one)
1. Description and/or narrative biography only.....
2. Motivational (perceives themes, meanings in attitudes and behavioral patterns, patient's feelings: interpersonal and intrapersonal factors).....
3. Other .....
4. Data not recorded.....

D. Type of Strategic Goals Selected by Physician (Check one)
1. Supervised living or decreased symptoms.....
2. "To improve socialization" (General statement) .....
3. Insight into symptoms or psychopathology.....
4. Insight into personal issues and/or capabilities.....
5. Interacting relationship between patient and physician .....
6. Other .....
7. Data not recorded.....

E. Type of Tactical Pattern Utilized by Physician (Check one)
1. Practical care only.....
2. Primarily passive, permissive.....
3. Interpretation, instruction prominent.....
4. Active personal participation (realistic, flexible interaction, initiative in sympathetic inquiry, challenge self-deprecatory attitudes, honest disagreement, set limits.....
5. Other .....
6. Data not recorded .....

change of physicians, usually because the physicians were shifted to other duties. In a few instances the change was considered desirable for the patient's welfare. For the purpose of this study we have designated as the patient's physician the one who was so serving at the time of the patient's discharge, and it is the record of his work with the patient which has been abstracted.

Comparisons and Contrasts.—Tables 4, 5, 6, and 7 present the factual material in a manner designed to test their relevance for improvement. The letters *A* and *B* are used in the various compartments to indicate patients treated by physicians of Group A or Group B.

Table 4 shows the high association between the patient's improvement and the type of relationship he developed to his physician. Of 48 patients who developed more confidential relationship with their physicians, 38 improved (27 A and 11 B); and of 52 who developed less confidential relationships, 40 did not improve (9 A and 31 B). This difference is statistically highly significant, beyond the .001 level, which means that the likelihood that it occurred by chance is less than 1 in 1000. This distribution of A's and B's

strongly suggests that the Group A physicians obtained their better improvement rates by their ability to gain the confidence of their patients. (The other tables give some indications as to how they gained this confidence.) But it is also suggested from Table 4 that when improvement did occur despite a less confidential type of patient-physician relationship, it was largely the A Group who obtained the improvement (9 A and 3 B); also when improvement did not occur, despite a more confidential patient-physician relationship, it was largely the B Group who failed to obtain the improvement (3 A and 7 B).

Another point apparent on inspection of Table 4 is the higher quality of improvement associated with increasingly greater confidence shown by the patients in the physician, this higher quality being manifested in increased social effectiveness and increased insight, in addition to decreased symptoms.

Table 5 was designed to test the relation of improvement to type of "Personal Diagnostic Formulation" made by the physician. The prevailing attitude in the Phipps Clinic is to foster an understanding of the patient's troubled life in terms of his personal experiences—the meanings and motives that can be discerned or inferred by observation, acquaintance, discussion, and reflection. This prevailing attitude of seeking and formulat-

TABLE 4

DIFFERENCES IN IMPROVEMENT ACCORDING TO KINDS OF RELATIONSHIP OF PATIENT TO PHYSICIAN

A—Group A
B—Group B

Relationship of patient to physician	Improved			Total	Unimproved	
	Decreased symptoms	+ Increased social effectiveness	+ Increased insight		Total	
Less Confidential						
1. Superficial social	A B					A BBBBB BB
2. Passive withholding	AA B	A		12	40	AAAAA AA BBBBB BBBBB BB
3. Aggressive rejecting	AAAAA	B				A BBBBB BBBBB BB
More Confidential						
4. Accepts support, depends..	AAAAA AA BB	AAAAA BBBB	AA			A BBB
5. Confides	B	AAAAA B	A	38	10	AA BBBB
6. Evaluates	A		AA B			
7. Problem solving			AAAA BB			
Totals				50	50	

ing a motivational understanding of behavior is not necessarily tied to the hypothesis of a psychogenetic etiology of the illness. It is equally consistent with melioristic aims or rehabilitation, as part of a general humanistic approach to all kinds of patients. Schizophrenic patients are obviously rather difficult for many persons to understand, and it is notable that, despite the prevalent attitude in the clinic, no motivational interpretation was formulated by their physicians in 30% of the schizophrenic patients of this series. Their Personal Diagnostic Formulations were essentially description and/or narrative biography. This fact made possible the construction of Table 5. Perhaps the most striking fact shown here is that very few patients improve (only 4 out of 30) when their physicians do not formulate in the clinical record some motivational understanding of their reactions. In contrast, of 69 patients whose physicians formulated some motivational understanding, 45 improved (33 A and 12 B). This difference is statistically highly significant, at the .001 level. The physicians of the A Group much more consistently recorded motivational formulations (in 41 out of 48 cases) than did the B Group (in 28 out of 51 cases) and it is suggested that this difference in approach is a strong factor in determining the relative therapeutic failure of the B Group.

We shall not undertake, in this communication, to discuss the correctness or incorrectness of the motivational formulations recorded in these case records or the cues or techniques used in arriving at such formulations. In general, many kinds of personal issues get involved in any troubled behavior problem of schizophrenic type, as well as of other types; hence, many different meanings can be distinguished in the symptoms and behavior. A perception and understanding of some one of these meanings may be a very good basis for a psychotherapeutic partnership; while a different physician might, in the same patient, perceive and understand a different meaning. Both might be equally valid, and equally useful psychotherapeutically. On the other hand, there is such a thing as an error, and a physician can make serious errors in his interpretation of the meaning of a symptom, or a bit of behavior. Such errors may seriously impede therapy; in other instances errors may break the ice, so to speak, and be mutually helpful toward better under-

TABLE 5

DIFFERENCES IN IMPROVEMENT ACCORDING TO TYPE OF PHYSICIANS' "PERSONAL DIAGNOSTIC FORMULATION"

A—Group A
B—Group B

Type of physicians' "personal diagnostic formulation"	Improved				Unimproved	
	Decreased symptoms	+ Increased social effectiveness	+ Increased insight	Total	Total	
Description and/or Narrative Biography	A	AA B		4	26	AAAA BBBBB BBBBB BBBBB BBBBB BB
Motivational	AAAAA AAAAA AAAAA BBBBB	AAAAA AAAA BBBB	AAAAA AAAA BBB	45	24	AAAAA AAA BBBBB BBBBB BBBBB B
Data not recorded		B		1		
Totals				50	50	

standing and communication. For our present purpose we have merely noted whether the physician did or did not include motivational interpretations in his personal diagnostic formulation of the patient.

Table 6 presents the correlation between the patient's improvement and the type of strategic goal selected by the physician. The fourth category represents the physician's aim of developing in the patient a better understanding of his capabilities and his potentialities for constructive resolution of his conflicts and troubled life situations. The fifth category represents the aim of developing and utilizing a dependable and meaningful personal relationship between patient and physician of a type which would serve to foster a new start toward greater confidence and freedom and some growth in maturity of personality. In Table 6 these 2 categories are combined as "Personality-Oriented Goals," and categories 1, 2, and 3 are combined as "Psychopathology-Oriented Goals."

These types of goals were not irresponsibly "dreamed-up" by the physicians merely because they seemed desirable, but were developed from the study of a patient's characteristics and history and were, of course, intimately related to the types of "Personal Diagnostic Formulation" developed for that patient.

The high association between the patient's improvement and the personality-oriented type of goals set by the physician (statistically significant beyond the .001 level) appears to reflect the favorable influence of the physician who finds in the study of his patient a basis for understanding personal meanings and who, on that basis, formulates a goal which is positively personal rather than merely antipathological. The physicians of the A Group more consistently formulated personality-oriented goals (in 35 out of 48 cases) when compared with those of the B Group (in 21 out of 50 cases).

TABLE 6

DIFFERENCES IN IMPROVEMENT ACCORDING TO TYPE OF STRATEGIC GOAL SELECTED BY PHYSICIAN

Type of Strategic Goal	Improved				Unimproved	
	Decreased symptoms	+ Increased social effectiveness	+ Increased insight	Total	Total	
I. Psychopathology-oriented Goals						
1. Supervised living or symptom decrease ...	AAAAA B	AA B	A			AA BBBBB BBBBB BBB
2. "To increase socialization"	B	B		12	30	A BBBBB BB
3. Insight into symptoms or psychopathology ..						AA BBBBB
II. Personality-oriented Goals						
4. Insight into personal issue and capabilities...	AAAAA BB	BBB	AAA B			A BBBB
5. Interacting relationship between patient and physican	AAAAA A B	AAAAA AAAA	AAAAA BB	37	19	AAAAA A BBBBB BBB
Data not recorded		B		1	1	B
Totals				50	50	

In Table 7 improvement is seen to be highly associated (statistically significant beyond the .001 level) with the tactical pattern which has been characterized as "active personal participation." Inclusion in that category means that the record shows that the physician, in his transactions with his schizophrenic patient, manifested initiative in sympathetic inquiry, expressed honest disagreement at times, sometimes challenged the patient's self-deprecatory attitudes, set realistic limits to what he could accept in the patient's behavior and avoided getting caught permissively, so to speak, in the patient's obsessive-compulsive patterns of control and manipulation. These characteristics are recognizable as manifestations of an attitude of respectful and sympathetic independence, on the part of the doctor toward the patient, combined with the expectation that the patient also has potentiality for respectful independent action.

The use of such tactics in appropriate situations is regarded very favorably by the chief of the service and other consultant personnel, and they were found to be used in a fairly high proportion of the cases (39), particularly by the A Group of physicians (in 31 out of 47 cases), not so much by the B Group (in 8 out of 46 cases). Among the 39 patients whose records showed the use of this tactical pattern, only 6 did not improve.

Improvement is much less frequently shown in Table 7 for the 3 other tactical patterns noted, which were, in the order of most frequent use: passive permissive (26 cases of whom 9 improved); interpretation and instruction (15 cases of whom 4 improved); and practical care only (13 cases of whom 3 improved).

Summary

In a study of the therapeutic successes and failures of 35 physicians, members of the resident staff of the Henry Phipps Psychiatric Clinic between 1944 and 1952, it has been found that success with one type of patient does not correlate very highly with success with a different type of patient. To

TABLE 7

Differences in Improvement According to Type of Tactical Pattern Used by Physician

A—Group A
B—Group B

Type of tactical pattern	Improved				Unimproved	
	Decreased symptoms	+ Increased social effectiveness	+ Increased insight	Total	Total	
1. Practical care only.....	AA	A				AAA BBBBB BB
2. Passive Permissive	B	AA BBBBB	B	16	38	AA BBBBB BBBBB BBBBB
3. Interpretation and instruction	AAA	A				AA BBBBB BBBB
4. Active personal participation	AAAAA AAAAA A BBBB	AAAAA AA	AAAAA AAAA BB	33	6	AAAA BB
Data not recorded.....		B		1	6	A BBBBB
Totals				50	50	

get a wide range of empirical facts, regarding factors significant for the improvement of schizophrenic patients, we selected for comparison 2 groups of patients, the A group 48 in number and the B group 52 in number, the A group having been treated by the 7 physicians who were most successful with schizophrenic patients and the B group by the 7 physicians who were least successful.

In the A group 75% of the patients were improved at discharge; whereas only 27% of the B group were improved.

So wide a difference can not be attributed simply to inherent differences between the A and B groups, because a detailed clinical comparison indicates only slight differences not statistically significant.

From analysis of nurses' notes, charts, conference notes, and other portions of our case records which served to supplement and check the physicians' notes, comparisons have been made as to differences in the way the physicians worked with these patients, and the way the patients responded. The comparisons and contrasts of these empirical facts, presented in Tables 4, 5, 6, and 7, indicate that improvement in the schizophrenic patient is most likely to occur:

(1) when the physician indicates in his personal diagnostic formulation some grasp of the personal meaning and motivation of the patient's behavior, going beyond mere clinical description and narrative biography;

(2) when the physician, in his formulation of strategic goals in the treatment of a particular patient, selects personality-oriented goals rather than psychopathology-oriented goals, *i.e.*, aims at assisting the patient in definite modifications of personal adjustment patterns and toward more constructive use of assets rather than mere decrease of symptoms or vague "better socialization";

(3) when the physician, in his day-by-day tactics makes use of "active personal participation," rather than the patterns "passive permissive," "interpretation and instruction," or "practical care."

These findings have been tested by statistical methods and are statistically significant beyond the .001 level of mere chance.

There is a similarly high association between improved condition at the time of a patient's discharge and the development by the patient, while in treatment, of a trusting, confidential relationship to the physician.

We interpret these empirical findings to mean that in the psychotherapy of schizophrenic patients success is to a large extent determined by the differences found among physicians in the extent to which they are able to approach their patients' problems in a personal way, gain a trusted, confidential relationship and participate in an active, personal way in the patient's reorientation to personal relationships. Techniques of passive permissiveness, or efforts to develop insight by interpretation appear to have much less therapeutic value.

ARTERIOSCLEROTIC MUSCULAR RIGIDITY WITH SPECIAL REFERENCE TO GAIT DISTURBANCES[1]

Clinico-Anatomic Study of Two Cases

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Arteriosclerotic muscular rigidity was first described by Foerster in 1909(1,2). The syndrome consists of a progressive muscular rigidity, slowness of movements, various types of gait disturbances, and mental deterioration. The rigidity involves the muscles of the extremities, the trunk, the neck, and face, and even the muscles of the eyes. The affected muscular groups appear hard to the touch.

MUSCULAR RIGIDITY

Frequently, there is marked rigidity of the neck. By pressure on the head the entire body can be moved in any direction. In turning the patient in bed, the body can be rolled over like a log of wood. Because of the muscular stiffness it is particularly difficult for the patient to change from a recumbent into a sitting position. After spending a night outstretched in bed, the patient at times is unable to adopt in the morning a sitting position, unaided.

Figure 1 shows one of Foerster's patients who has been taken out of bed to be placed on a chair. Rigidity and contracture of the extensor muscles of the knees and hips prevent the patient from bending his knees to assume a normal sitting position. In extreme instances, the assistance of the nurse is required to flex the legs. Likewise, after a patient has been seated for a while and is then urged to stand, the contracture of the flexor muscles of the knees and hips, which has developed while sitting, offers a resistance that can be overcome only with difficulty.

In Figure 2, the patient has been helped into a position, halfway between lying down and sitting up. This is a most uncomfortable position to the normal person, but the arteriosclerotic patient with muscular rigidity will remain in this posture without effort. Extremities, which have been placed in abnormal positions, will retain these postures for a considerable time, showing similarity with the phenomenon of "catalepsy."

The facial expression becomes fixed. Individuals who previously had an active mimicry can hardly be recognized. The patient speaks in a low voice because of the rigid condition of the muscles involved in the formation of words. Swallowing is often impeded for the same reason.

As time goes on, the rigidity increases until the patients lie helplessly in bed, sometimes with contractures in hips and knees, the so-called paraplegia in flexion of cerebral origin(3). Decerebrate forms have also been observed.

Slowness of Movements.—The muscular rigidity is the basic cause for the slowing of all motions; fast movements can no longer be executed. It is an effort for the patient to move. Changes in the facial expression—laughing or crying—develop slowly and persist longer. Chewing of food requires more time. Handwriting is impaired. Characteristic is the small size of single letters. Later writing may become impossible. Early there are difficulties in buttoning the clothing, which makes a good test for adiadokokinesis, an important abnormality in this condition.

Disturbance of Gait.—Often an early symptom is a disturbance in walking as the lower extremities are always first and most severely affected by the muscular stiffness. A distinctive feature in the majority of patients is the gait with small steps, the shuffling gait—the *marche à petits pas* of the French. This may be preceded by staggering and a certain insecurity in walking, indicating a disturbance of equilibrium. The patients

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stumble and fall easily. The sense of balance may become so disordered that the patient has to resort to 2 canes. In other instances, the disturbed equilibrium leads to an ataxic gait: the individual walks on a wide base, using the arms as a balance. Because of the muscular rigidity, the vertebral column and the pelvis remain immobile. The patient barely bends the knees. The feet scrape on the floor. The slow beginning and the limitation in the execution of movements, such as steps, result from the resistance of the rigid agonist and antagonist muscles, which put a brake on the execution of every motion. The stiffness of the limbs may progress to the point where both walking and standing are impossible. Without support the patient topples over like a rigid puppet. In instances of a one-sided development of the rigidity, he falls toward the affected side.

There are numerous variations in the gait disturbances. They depend on the extent and location of the cerebral softenings in the regions related to normal equilibrium and gait.

The ataxia, which co-exists with the spasticity, is at times not far removed from that of tabes. If lesions are present in the cerebellum, components of a cerebellar gait are added to the syndrome.

Reflexes.—The pupils are small and not infrequently slightly unequal and irregular; they are almost always sluggish to light. Both the Argyll Robertson type of pupils (Foerster) and fixation to both light and accommodation (Bumke) have been reported.

In the initial stage, the knee jerk is near normal, but the extension ("kick") of the leg on tapping the tendon of the quadriceps extensor is reduced. In some patients, the patellar reflex is increased. In the later stage, this reflex is often diminished and may disappear entirely. Occasionally, there is a positive Babinski sign. The abdominal reflexes are frequently absent. The reflexes of the upper extremities show little or no change.

Tremor is usually absent. Sensation is intact. But the patients may complain of paresthesias, such as burning, in the lower extremities. An urge for frequent urination is often present, and there may be difficulties in starting the stream. Later, there are various degrees of incontinence of bladder and rectum.

Any other neurologic symptom, such as a fleeting aphasia, dysarthria, Jacksonian convulsions, mind blindness, pseudobulbar palsy, etc., may be observed.

Mental Changes.—Almost any type and degree of mental abnormality may be present. In the late stage, the intellectual deterioration may resemble the profound dementia of general paralysis, and a differential diagnosis can be made only by an examination of the cerebrospinal fluid.

Development of Muscular Rigidity.—In a considerable number of cases, muscular rigidity appears following one or more slight strokes. After a few weeks the paralysis of the extremities disappears, but is followed by a one-sided slowly increasing muscular rigidity. In other patients, the condition develops in the absence of any obvious apoplexies. In both instances, the muscular rigidity is caused by cerebral softenings. In cases developing in the absence of an apoplectic insult, the cerebral softenings are so small that they remain asymptomatic, except for the resulting stiffness of the musculature. If the rigidity begins in one side only, this will usually be followed by an involvement of the other side as the softenings rarely remain unilateral. However, an occasional patient will retain the one-sided rigidity until death, or one side may always remain more rigid than the other.

Report of Cases

Case 1: Arteriosclerotic muscular rigidity developing insidiously without evidence of small strokes

History.—J.H.M., a locomotive engineer, at the age of 60, while apparently in the best of health, showed loss of muscular coordination. He had difficulties in buttoning his clothing and became awkward and slow in operating the various instruments in the engine cab. After a fall, while descending from the engine, his physical disability was noted, and he was retired. Within the next 2 years, he developed a progressive mental deterioration and a speech impediment, accompanied by a gait disturbance, diagnosed as locomotor ataxia.

When he arrived at the hospital, he walked in small steps with the support of 2 canes. He clung desperately to the canes because, without them, standing was impossible.

Physical examination revealed a generalized muscular rigidity, most advanced in the lower extremities. There was a marked disturbance of

equilibrium. Pupillary reactions and knee jerks were near normal. There was no tremor. Hearing was slightly impaired. Blood pressure was 180/110.

A cerebrospinal fluid examination, which was done once a year, revealed a 2 plus Pandy and a 2 plus Ross test, with the total protein oscillating between 45 and 55 mg. The cells were below 5 per cmm. There was no change in the colloidal gold test. The Wassermann reaction of the cerebrospinal fluid and of the blood was negative.

The urine, on admission, was normal, but in the second year began showing a slight trace of albumin and a few hyaline casts.

In the year prior to death, following a few attacks of brief unconsciousness which were interpreted as slight strokes, the patient retired first to a wheel chair and finally to bed. He died 4 years after the onset of the illness from acute pulmonary edema, caused by failure of the left ventricle of the heart.

Postmortem Observations.—There was marked atherosclerosis of the vessels at the base of the brain. Minute old and recent softenings were scattered throughout the brain, with a predilection for the basal ganglia. Some of these foci were so small that they were barely visible on gross examination.

In the putamen and optic thalamus of either side there was the greatest number of softenings, varying from 1 to 2 mm. in diameter. The globus pallidus, substantia nigra, pons, and cerebellum were free of gross changes.

Microscopic examination revealed additional old and recent softenings in the caudate nucleus, putamen (Fig. 3), internal capsule, and in the pons. In the striate bodies were also areas in which the ganglion cells had completely disappeared. Foci of incomplete demyelination and of glial proliferation were observed in the white matter.

The globus pallidus was free of microscopic lesions. In the substantia nigra was one occluded arteriole, which had produced a limited disintegration of neurons, but the large majority of the ganglion cells of the substantia nigra was intact.

In one caudate nucleus was a mass of golden yellow pigment, encircling in part an otherwise normal large artery. The surrounding tissue was sprinkled with similar coarse yellow pigment granules.

In the cortex were a few old and recent softenings and several acellular areas.

The small foci of cerebral softening were due to fibrous obliteration of arterioles, caused by proliferation of the endothelial cells. Frequently, such arterioles showed hyalinization of the media and at times a cellular proliferation in the adventitia, consisting of lymphocytic and plasma cell-like cells.

In the spinal cord was slight demyelination in both pyramidal tracts, more advanced on one side (Fig. 4). Some arterioles revealed similar changes as in the brain, but complete occlusion was never observed.

Other important postmortem findings were hypertensive (arteriosclerotic) heart disease with hypertrophy of the left ventricle, moderate coronary and aortic atherosclerosis, and arteriosclerotic kidneys.

Comment.—In this patient, the muscular rigidity had developed insidiously in the absence of any sign of apoplexies, and only in the last year did small strokes make their appearance. At autopsy, some of the multiple foci of softening were so small that they were noticeable only to an expert eye, and others were detected by microscopic examination.

The disability had developed unnoticed in an individual engaged in the operation of a locomotive. His awkwardness and slowness in operating the numerous devices in the engine cab had for some months made this person unfit for his occupation. Only after the muscular incoordination had become so great that it led to his falling from the engine cab was the condition recognized. The serious implications involving public safety are too obvious to necessitate further comment.

CASE 2: ARTERIOSCLEROTIC MUSCULAR RIGIDITY DEVELOPING AFTER A STROKE

History.—C.B., a white male of pyknic body type, at the age of 65, experienced a slight stroke, involving mainly the right arm. The paralysis disappeared within a few weeks. In the succeeding months it became difficult for him to carry on with his occupation as a tailor because of an oncoming slowness and awkwardness of all movements of the fingers. At the same time his gait became impaired. Eighteen months after the initial stroke he became depressed and attempted suicide.

On admission to Central State Hospital, he walked on a wide base, using his arms as a balance. His feet stuck to the floor and with every step he moved forward less than half the distance of a normal person. At times the difficulty in walking became so great that he had to be supported by the nurse. He was unable to maintain his balance with his feet together and eyes still open.

There was hypertonus of all muscles. This was most marked in the calf musculature. Both patellar reflexes were exaggerated. There was an indication of a positive Babinski sign on either side. The pupils were midwide, regular in outline, and reacted normally to light and accommodation. Arcus senilis was absent. The right side of the mouth was slightly drooping. The grip of the right hand was weaker than the left. Fast movements of the fingers were slowed, particularly in the right hand.

The patient displayed a slight euphoria, in contrast to his previous depression. There was marked enfeeblement of the intellect.

The blood pressure varied between 190/90 in the morning and 210/120 in the late afternoon. The fundi showed marked retinal arteriosclerosis. The electrocardiogram was normal. Roentgenologic examination revealed left ventricular hypertrophy, a prominent aortic knob, and ectasia of the aorta.

The Wassermann of the blood and of the cerebrospinal fluid was negative. In the spinal fluid was 1 cell per cmm.; the Pandy and Ross tests were negative; the total protein was 23 mg.; and the colloidal gold reaction was normal. The urine showed a slightest possible trace of albumin and

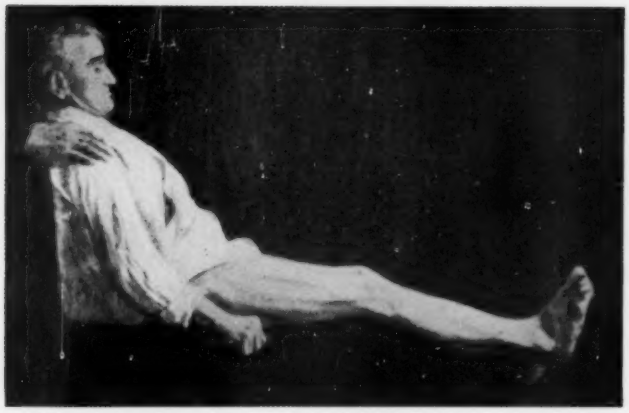

FIG. 1.—Arteriosclerotic muscular rigidity. Contracture of the extensor muscles of the knees and hips prevent the patient from assuming a normal sitting position. (From Foerster, *Ztschr. f. d. ges. Neurol. u. Psychiat.* 73: 1, 1921).

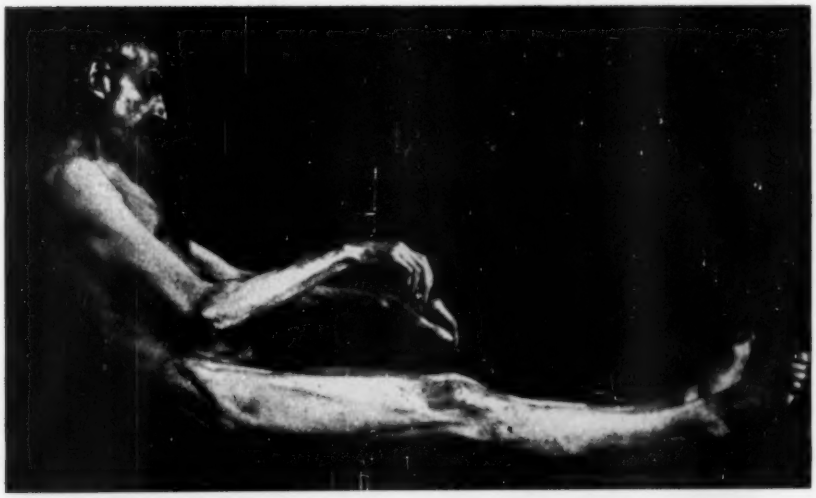

FIG. 2.—Arteriosclerotic muscular rigidity. The trunk and extremities retain abnormal postures for a considerable length of time, suggesting the phenomenon of "catalepsy." (From Foerster, *Ztschr. f. d. ges. Neurol. u. Psychiat.* 73: 1, 1921).

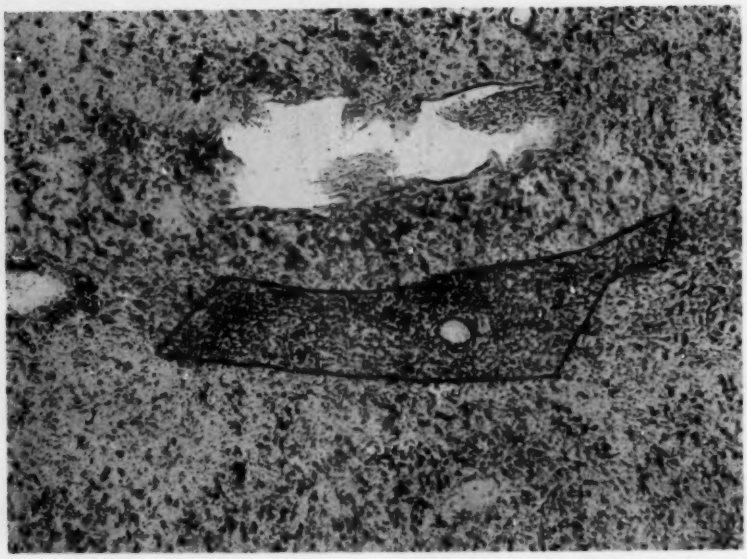

FIG. 3 (Case 1).—Putamen: Microscopic area of recent softening, with compound granular corpuscles (encircled). Immediately above is an old cystic area of softening of about equal size. Disturbance of the normal cellular architectonic in surrounding tissue. Toluidin blue stain.

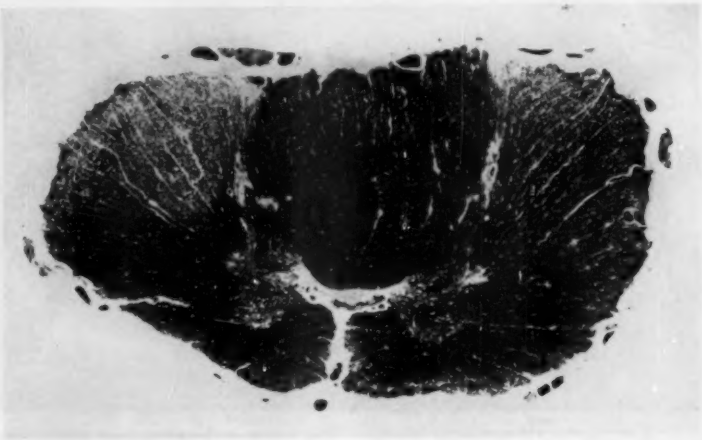

FIG. 4 (Case 1).—Spinal cord with slight degeneration in both pyramidal tracts, more advanced on one side. Myelin sheath stain.

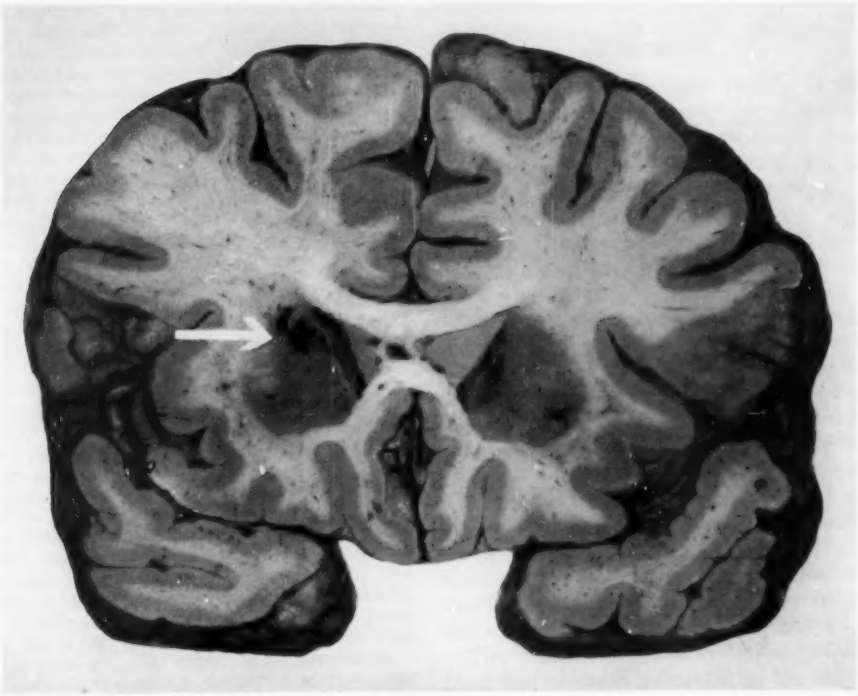

FIG. 5 (Case 2).—Cut through anterior portion of caudate nucleus. There are two cystic foci on one side (arrow). The minute areas of softening in the opposite caudatum are less obvious.

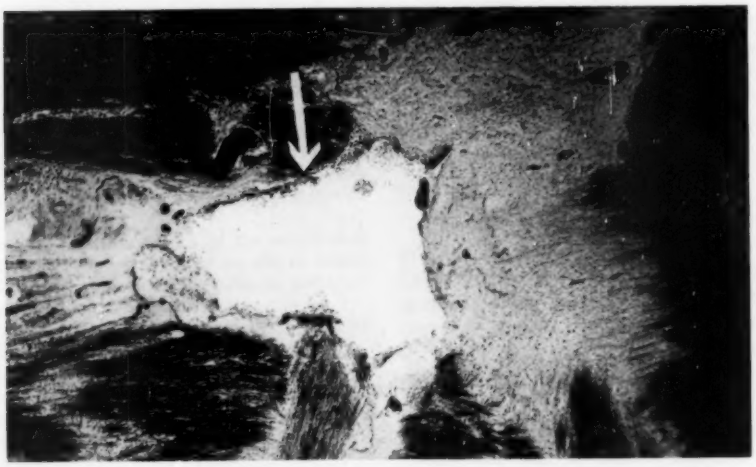

FIG. 6 (Case 2).—Small cystic area of softening in pons. Myelin sheath stain.

an occasional hyaline and granular cast. The white blood cell count ranged between 9,200 and 11,600, with a slight shift to the left; red cells numbered 5,120,000. The sedimentation rate remained slightly elevated during the entire course of the illness.

In the 6 months prior to death, the patient was bedfast because of muscular rigidity. He died 4 years after the onset of the disease from bronchopneumonia.

Postmorten Observations.—In the vessels at the base of the brain were yellow atherosclerotic plaques, but the lumina of the basilar and middle cerebral arteries were little narrowed. The meningeal arteries were free of atherosclerosis. Atrophy of cerebral convolutions was absent.

Dissection of the hardened brain disclosed minute areas of softening in the white matter of the hemispheres, including the corpus callosum. The largest of these softenings, 10 x 8 mm. in diameter, was in the fibers of the left corona radiata coming from the arm area. This focal lesion might have been the cause of the transient paralysis of the right arm. The greatest number of small softenings was present in the striate bodies of either side (Fig. 5). The largest of these cystic degenerations was located in the right putamen, being 10 x 2 mm. in size. Other minute softenings, 1 x 2 mm. in diameter, were observed in the internal capsule, in both optic thalami, and in the pons (Fig. 6). The pontine lesions involved the fibers of the pyramidal and of the fronto-ponto-cerebellar tracts. There were also a few small cystic areas of degeneration in the white and grey matter of the cerebellum.

Histologic examination unearthed in the white matter of both cerebral hemispheres an occasional small focus of demyelination and additional recent and old softenings. Similarly, microscopic softenings were observed in regions of the basal ganglia, which appeared normal on gross examination. A few of these were filled with compound granular corpuscles, indicating their recent origin. Some of the arterioles in the basal ganglia and white matter had a thickened hyalinized media and the remaining lumen was often completely obliterated by intimal proliferation.

In the walls of both middle cerebral arteries there was deposition of lipid material, which was walled off by fibrotic tissue, but leaving the size of the lumen little altered.

In 9 out of 19 tissue blocks of the cortex that were examined, there was either an old or recent area of softening or an acellular area, in which all the ganglion cells had disappeared.

There was slight degeneration of the pyramidal tracts in the spinal cord.

Comment.—In this patient, a little stroke was the beginning of the muscular rigidity, which manifested itself mainly in the development of a spastic-ataxic gait to which was added a cerebellar component.

The large vessels at the base of the brain displayed a relatively moderate amount of atherosclerosis. The main vascular process was in the small arterioles, consisting of medial hyalinization, often associated with terminal occlusion by intimal proliferation.

Discussion

Arteriosclerotic muscular rigidity is due to innumerable small areas of cerebral softenings, which may be so small that they remain microscopic and subclinical, except for the muscular stiffness. In other instances, a slight stroke initiates the condition. The presence of old and recent softenings is indicative of the continuity of the process after it once has started.

The small cerebral softenings are the result of disease of the arterioles, consisting of hyalinization of the media, which may become several times its normal thickness, leading to narrowing of the lumen. In some instances, the lumen becomes entirely obliterated by proliferation of the intimal cells. The areas of softenings are, therefore, due to organic vascular occlusion and are not caused by functional, so-called vasospastic phenomena. As a rule, if there is extensive vascular disease in a certain region, there is also extensive damage to the parenchyma.

The process in the arterioles is different from that of the large vessels at the base of the brain in which plaques of lipid deposits, walled off from the lumen by fibrous tissue, are the main lesions.

In neither brain was there histologic evidence of "thrombosis," which customarily has been assumed to be the cause of the occlusions. This fact is of importance in any therapeutic attempts to influence the vascular disease(4).

SITE OF THE MAIN LESIONS

Although there is a diffuse arteriosclerotic process of the brain, it is important to delineate more precisely the main site of the multiple softenings, as not all patients with cerebral arteriosclerosis develop the syndrome of muscular rigidity. Foerster(1) located in 2 instances the main softenings in the middle cerebellar peduncles (brachia pontis). He deduced that the muscular rigidity was due to involvement of this particular anatomic structure, which contains the fronto-ponto-cerebellar tract. In Foerster's publication of 1921(2), the prevailing

idea was that the rigidity originated mostly from lesions in the globus pallidus, but no anatomic examinations were reported in this purely clinical study. Grinker(5) accused the substantia nigra and the globus pallidus for the production of the syndrome.

In both our cases, the globus pallidus and the substantia nigra, with the exception of one isolated area in case 1, were free of lesions. The largest number of gross and microscopic softenings were found in the striate bodies. Rigidity and bradykinesia have been considered for many years signs of disease of the striatum.

Foerster(1) emphasized that the rigidity was not connected with an involvement of the pyramidal tract. However, in our cases, examination of the spinal cord revealed slight bilateral degeneration of the pyramidal tract, resulting from the summation of numerous small areas of softening as the corticospinal fibers pass through the brain. In the spinal cord itself, the blood vessels revealed only minor changes, and for that reason there were no changes dependent on ischemia.

Of paramount importance in causing the syndrome of arteriosclerotic muscular rigidity are the numerous minute areas of softening and demyelination in the white matter, involving the fronto-pontine tract, as these fibers pass from the frontal lobe through the corona radiata and the anterior limb of the internal capsule to the pons. It is in these fibers that the impulses for volitional skilled movements are mediated, their impairment manifesting itself in difficulties of buttoning clothing. Other tracts passing through the white matter are injured, *e.g.*, the parieto-temporo-occipitopontine tract, which is of importance in its function of equilibration. All these efferent motor pathways play a role in balance and muscle tone by their effect on the lower motor neurons and the muscles which they control.

ARTERIOSCLEROTIC MUSCULAR RIGIDITY VERSUS ARTERIOSCLEROTIC PARKINSONISM

The muscular rigidity resembles that of idiopathic paralysis agitans. The analogy is particularly obvious in cases of Parkinson's disease without tremor. Foerster(1) thought that the differentiation could be made from the severe end stages, such as contractures, and from associated signs attributable to the diffuse cerebral arteriosclerosis. Bonhoeffer in discussing Foerster's paper(1) mentioned that all his cases of arteriosclerotic muscular rigidity displayed dementia; this sets them apart from the idiopathic type of paralysis agitans.

In the interim, the term arteriosclerotic Parkinsonism has been introduced(6, 7). Davison(8) studied 18 such cases. In his series he included patients with the characteristics of the Foerster type of arteriosclerotic muscular rigidity.

Both terms have their clinical justification. The 2 patients described in this study did not suggest arteriosclerotic Parkinsonism. Their outstanding symptoms were the disturbance of equilibrium and of gait. Such cases are best placed in the group of arteriosclerotic muscular rigidity.

SUMMARY

The syndrome of arteriosclerotic muscular rigidity results from a partial involvement of various systems (fronto-ponto-cerebellar tract, pyramidal and extrapyramidal system), rather than from an affection of 1 or 2 special cerebral centers.

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PSYCHODYNAMIC AND CLINICAL OBSERVATIONS IN A GROUP OF UNMARRIED MOTHERS[1]

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It is well known that women with all types of behavior patterns and many varieties of emotional disorder become unmarried mothers. Motivation to the specific experience of unmarried motherhood depends to some extent on the degree of emotional illness and the personality of the patient. There is a growing volume of literature on clinical investigations and psychodynamic formulations of some of these problems. In the present study, it is hoped that some of the earlier observations and concepts may be supplemented with data on a somewhat larger case material.

The setting of this investigation is a privately endowed maternity home in New York City. Fifty-four consecutive referrals were seen once or twice in psychiatric consultation. The social workers provided a concise history of patients in most instances. The group ranged in age from 15 to 39 years and represented a reasonable cross section of the community in terms of socio-economic background and education.

Personality evaluation or diagnostic classification was made on the basis of historical data, present clinical status, and functioning in the residence hall. A diagnosis of character disorder was based on evidence of passive-aggressive or passive-dependent functioning, some degree of emotional immaturity, the prominence of such ego defense mechanisms as acting-out, denial, displacement, reaction formation, and the pursuit of some magical resolution of problems. A diagnosis of anxiety, depressive or conversion reaction, was made whenever there were leading symptoms of that nature. Schizophrenia was diagnosed in patients in whom the primary symptoms of the disorder obtained. The pseudoneurotic category was used to designate those who, in addition, had numerous neurotic mechanisms, gross emotional dysregulation, and chaotic sexuality. The other subcategories of schizophrenia were used according to the standard criteria. Patients with character disorder were differentiated from those with pseudoneurotic schizophrenia on the basis of the primary symptoms of schizophrenia and pan-neurotic symptoms in the pseudoneurotic group. The psychopathology in the character disorder group was quantitatively less severe and qualitatively less ramified.

The following distribution of diagnoses was found: character disorder, 30; neurotic reaction, 7 (anxiety, depressive, and conversion); schizophrenia, 17 (pseudoneurotic, 7; other types, 10).

One schizophrenic patient was rejected on psychiatric grounds and another had to be sent to a psychiatric hospital after admission because of an acute psychotic episode. The other 15 patients with this diagnosis continued to term without acute emotional complications, though in contrast with the non-schizophrenic group, there were obvious differences in ego strength and ability to cope with reality. In most instances, these deficiencies had been present in many areas for most of the patient's life. A great majority of the schizophrenic group had a history of a broken home (loss of one or both parents by death, divorce, separation, or mental illness years before the pregnancy), and a higher incidence of recognized or evident mental illness in the family was noted. The responses of these patients to environmental vicissitudes were usually rigid, unrealistic, and there was an illogical expectation that problems would be resolved by the magical effects of certain behavior. The relationship of such patients to a parent or parent-surrogate was often one of extreme dependency, to the point of psychological addiction, and the emulation of parental behavior or defiance of parental mores was carried out on a very concrete basis. Sexuality in this group was chaotic and the motivations to intercourse were usually vague and unreal, as was

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the relationship to the putative father. The latter was often a casual acquaintance who was repudiated by the patient with the advent of pregnancy, or an older man, often married, who fulfilled the role of understanding father in the patient's literal dramatization of this wish. These men lost interest in the patient with pregnancy or proposed continuation of the relationship after the child had been placed for adoption. A majority of the schizophrenic group planned to keep the child in contrast with only a minority of the nonschizophrenic group. These plans were formulated in some instances on the basis of regarding the child as a supplementary ego to be completely possessed, who would be a dependable and lifelong source of love for the patient. Some planned to keep the child as a lever to facilitate the legalizing of the illicit relationship with the married man. Others were pressured by not too healthy mothers to bring the child home, either to fulfill a need in the life of the mother or to insure a firm tie between patient and the home with a mother-daughter-grandchild group as a substitute for the father-mother-child domestic role. Some patients had little apparent interest in a continued social and sexual relationship with the man, using him only to sire a child and then to have the child without the problems of living with a man. The patient's father could be retained in fantasy to complete the triangle.

Many other real or apparent determinants of behavior could be mentioned for this group. To some extent, these obtain in association with the chaotic thinking, emotionality, and sexuality which are so evident in these patients.

The 37 nonschizophrenic patients demonstrated much more flexibility in coping with reality despite variable disturbances in the nature of character disorder or neurotic illness. There were qualitative and quantitative differences in reactions in contrast with the schizophrenic group, including more inclination to abstract, logical responses, and less tendency to the use of denial, acting out, displacement and projection in the concrete, literal sense. The ability to initiate and sustain emotional relationships was much better, often despite numerous traumatic experiences. It is possible to achieve a better understanding of the psychodynamics of these patients inasmuch as one can more clearly establish some meaningful sequence of environmental experiences and the patient's reaction to them. Multiple determinants of behavior continued to obtain but one could differentiate the primary factors more easily from the accessory ones.

A majority of the patients with character disorder or neurotic illness had a history of a broken home, though the percentage was not as great as in the schizophrenic group. However, there was striking evidence of distortion and disturbance in the patient's relationship to her father in almost all of the group. The patient had had little or no opportunity to achieve concepts of the role of father, husband, or man in the domestic and social milieu. In those instances in which the patient had grown up in a intact home, the father was usually a passive, ineffectual person who either resignedly tolerated the girl as another inexplicable female or idolized her in a somewhat seductive manner. Some of the fathers were unpredictable strangers to the patients in the sense that they were seldom at home when the patient was, or, having functioned as a father for a period, would suddenly lose interest in the home and move in with another woman. Concepts of a stable, responsible man of the house and father of the family were difficult to crystallize. A few of the fathers and some of the step-fathers were brutal, exploitative, or seductive in their attitude toward the patient. The mothers or mother-surrogates of patients in this group introduced further complexity into the patient's discovering her own identity and gaining concepts of the mother-wife-woman role in life. These women, with or without husbands present, usually "wore the pants of the family," assuming many of the male prerogatives in domestic and community activities. In some instances, there was a possessive, harsh, demanding attitude toward the patient, a cool attitude of rationalized neglect, or a begrudging acceptance of an unruly child who seemed alien to the family. One factor, noted with striking regularity in this group, was a feeling of not belonging, not having a close emotional bond with someone, and compensatory activity to

achieve a feeling of being loved. This feeling of a lack of love was predominantly based on reality factors rather than individual emotional deficit and social retirement. However, negative attitudes toward family were, for the most part, repressed and denied and appeared only obliquely in various types of displacement or acting-out behavior.

The relationship to the putative father varied from real or invited rape by an unknown to a 10-year affair with a married man. Some were boy-friends or "rebound" boy-friends, following the termination of another relationship. Many of these men had a façade of tender devotion and deep interest in the welfare of the patient, but an underlying exploitative and irresponsible behavior. The patients often denied the presence of these fairly obvious characteristics in the men and responded to the superficial aspects they wished to see. In many instances, the putative father was several years older than the patient and fulfilled some of the fantasies of the ideal father. Only in exceptional cases did the putative fathers offer emotional or financial support after pregnancy was recognized. Several of the patients preferred not to inform the men of their plight and a few refused assistance. Inasmuch as many of the patients had a lifelong experience of rejection or repudiation, some probably expected the pattern to continue and, to some extent, may have invited it. A vague recognition of some of the unconscious incestuous connotations of the relationship was another factor in arranging for desertion by the putative father. A few quickly shifted emotional interest to another man in an effort to deny the entire experience.

Some of the other motivations to intercourse and impregnation included emulation of sexual behavior of important persons in the life of the patient as well as defiance of family and social mores. Curiosity and confusion about sexuality was a fairly common determinant, while sexual pleasure motivated some whose relationships were more protracted. Though most of the patients were aware of the possibility of impregnation without contraception, many felt that this did not apply to them, that they would be magically protected, a further example of denial. Intercourse and child-bearing were considered by some as a magical route to maturity and a resolution of problems. A number spoke of their wish and need to continue a relationship with the man and feared sexual refusal would drive him away. Some women wished to force married men to seek divorce and wed them.

After a period of ambivalence during pregnancy, most of these patients decided to place the child for adoption. With those who decided to keep the child, there was often defiance of family wishes for adoption and a few hoped to attract the man to marriage. Manifest evidence of the more primitive motivations to keeping the child, as seen in the schizophrenic group, was not striking, though such material might be revealed with more intensive investigation.

A comparison of behavior and of various determining factors in the actions of younger and older adolescent age groups and young adult and adult age groups revealed more likenesses than differences. The majority of the patients in all age groups were bound to a parent or parent-surrogate with adolescent ambivalence about dependency, defiant resentment, and some confusion about emotional relationships. Just as each patient had a unique set of motivating factors, each age group showed certain differences from the others. There was some evidence of increasing incidence of emotional disability and psychopathology proceeding from the younger to the older groups.

There were no significant physical or emotional complications in this group in specific relationship to the puerperium. There were 2 stillbirths and in each there was some question of attempted interference with drugs early in the pregnancy. Another patient delivered a viable infant in the seventh month of gestation but the child died a few minutes later. The patients were delivered in various hospitals, either as ward or private patients. The gross infant mortality rate for this group, including the premature infant who died, is 5.55%. This does not compare unfavorably with the infant mortality rate of 3.36% at a large medical center(1).

There are numerous problems in the technique and application of psychotherapy in a maternity home setting. Patients have a number of pregnancy-specific problems relating

to hospitalization, plans for the child, attitude toward putative father, and future plans for self. In addition, there are the personality-specific problems of much greater magnitude and more subtle connotation. On a more superficial level, these include attitudes toward family, friends, and self, and some of the meaningfulness of behavior in terms of acting-out, displacement, and other mechanisms. Other issues of character structure and symptom formation on a more profound level would require much more extensive investigation and intensive treatment. An effort was made to help the social workers limit the goals of treatment in view of the short time available and the heavy case-load. In treating patients who were quite disturbed emotionally, it was suggested that most of the efforts be confined to pregnancy-specific problems and even these proved too formidable to be adequately handled by some patients. Concerning some of the other patients, it was suggested that ventilation of the more superficial aspects of personality problems could be facilitated, with an occasional comment by the worker on some of the possible meanings of behavior in present-day terms.

Despite the obvious need for therapy and the efforts of the staff, a majority of the patients seemed averse to any opportunity for clarification of personality problems during or after the pregnancy. They cherished their defenses, however unsuccessful they had proved to be, and were eager to return to the *status quo*. This was a further reason for limiting the goals of therapy and for suggesting that defenses should be left intact unless something better could be offered.

The role of the social worker in this setting is most difficult in view of the circumstances noted above as well as in association with countertransference and subjective emotional reactions of the worker.

Discussion

An attempt to organize and integrate clinical and psychodynamic material on any sizable group of patients is a humbling and arduous task which will increasingly occupy the student of clinical research in psychiatry. The problem is compounded as one approaches such a widely ramified issue as unmarried motherhood. Excellent reports of smaller groups have been presented by Bernard(2, 3), Clothier(4), Deutsch(5), Kasanin and Handschin(6), Reider(7), and others.

Space limitations preclude use of much of the fascinating and extensive case material; however, the sample is as large and unselected as possible.

The individual is seen as the emergent, integrated product of his basic endowment, his nursery and early childhood experiences in the family, and his response to them, as well as the impact of subsequent biological, social, and other experiences at a given time in his development. Clinical data suggest that in some individuals there may be an inherent deficiency in potential for integration, with a low threshold to stimuli from within and without and inability to cope with environmental vicissitudes(8). The needs of different individuals may vary remarkably from birth, and various techniques of care, love, and training are applicable to various persons for optimal facilitation of integrated development. To the extent that much of the development of the concepts of oneself, of the sexual differences, of the behavior of male and female, husband and wife, father and mother, are based on passive emulation, especially during the early years, the relative intactness of the family is most necessary. The importance of the father and mother fulfilling their respective roles, as seen in this culture, is paramount.

It must also be noted that evidence of certain dynamic mechanisms varies according to the relative intactness of the personality of the patient. Those with integrative disability, low threshold to stimuli, and disordered thinking processes, equivalent or tantamount to primary process thinking, usually present much more material in terms of regressive or fixated mechanisms and chaotic sexuality. These factors must be considered in formulating psychodynamic mechanisms in relation to a specific patient or to a special symptom such as unmarried motherhood.

The somewhat bold attempt to use diagnostic categories in this study was prompted by a wish to obtain a better understanding of the problem in a relatively unexplored

area and to indicate certain possibilities as to goals of therapy. It was astonishing to discover, upon tabulation of the material, the distribution of diagnoses: 30% of this group of 54 were diagnosed schizophrenic. It is quite possible that other investigators might have made a somewhat different interpretation.

Schizophrenia in an unmarried mother may make a difference in the decision to admit or to keep her on the roles of a given agency or maternity home. This material demonstrates that of 17 patients with this diagnosis, all but 2 were cared for through parturition. The others made a variable adjustment and the very fact of recognizing the illness facilitated understanding and flexibility in the staff. It was possible to warn the social workers to be cautious about pursuing emotionally-charged material that, once recognized, might not be dealt with adequately in the short time available. Thus, it must be emphasized that, despite integrative deficiency and emotional disability of variable severity, these patients have some adaptive capacity and are accessible to some psychotherapeutic and social assistance in a maternity home.

The numerous motivations to keep the child have been touched on and have been well described in the literature. The reality awareness of the schizophrenic is impaired and may be quite evident in unrealistic, vague plans about keeping the child. It has been noted that a large majority (70%) of the nonschizophrenic patients selected adoption for the child, while a small majority (54%) of the schizophrenic patients decided to keep the child. The extent to which staff members are able to influence this decision, or should try to influence it, is a matter for further investigation.

Several of the investigators noted above have reported remarkable results with psychotherapy conducted over a reasonable period in family agencies, clinics, or private practice. The unmarried mother, especially in adolescence or early adulthood, has manifest evidence of personality difficulty, usually with other more chronic problems. If sufficient facilities were available and various agencies dealing with unmarried mothers were adequately coordinated, it might be possible to have more of these patients enter psychotherapy. Technique and goals of therapy would vary according to the patient's integrative capacity. This could be a definite contribution to preventive and therapeutic psychiatry and might obviate recidivism. A 5-year follow-up study of a sizeable group of unmarried mothers, with and without psychotherapy, would further help in clarifying this and many other of these problems.

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DISCUSSION

VIOLA M. BERNARD, M. D. (New York City).—In evaluating Dr. Cattell's figures on psychiatric diagnosis and comparing them with reports of other investigators, an important selective factor in his sample must be borne in mind. Dr. Cattell's series is drawn exclusively from a maternity home. Large numbers of unmarried mothers seek no agency help whatever for many reasons and of those with agency contact during the antepartum period only a fraction enter maternity homes. The reasons for this include not only practical considerations but complex psychodynamic determinants. The protective group setting of the shelter usually appeals to the more dependent and immature of unmarried mothers. The assumption is unwarranted that this maternity shelter group is psychiatrically representative of the much larger number of unmarried mothers among whom, as we know, very great variations prevail as to personality structure and the nature and degree of psychological disturbance.

In New York City recently it was roughly estimated that only about 1,200 unmarried mothers use agency resources annually out of at least 7,200 illegitimate births a year in New York hospitals. The latter is a minimal figure and does not include the

nonresident girls or the large number who enter hospitals as married although they are not. Many situational factors, of course, including economic need, the quality and quantity of available resources in the community, and how these are publicized influence the seeking of help. We find two opposite extremes, from the psychiatric standpoint, among those who never use agency contact—the healthiest and the sickest. Relatively more mature individuals with greater inner resources often mobilize their own ways of meeting the situation. Those most severely disturbed may lack the ability to make plans or to face the problem of seeking and following through with appropriate help. Thus we would not expect to find that the incidence and distribution of psychiatric disorders for unmarried mothers in general would be the same as has been found for the series selected from a maternity shelter.

It may be of interest to compare Dr. Cattell's figures on psychiatric diagnosis with those made on a group of 91 cases in a recent, unpublished study by an agency with which I am associated that provides a variety of casework services to unmarried mothers. Shelter care is but one of the alternative resources at its disposal. The clinical diagnosis was established by Dr. Ruth Rabinovich, the consultant psychiatrist, in all cases, only some of whom, however, were directly interviewed by her. This contrasts with Dr. Cattell's series of 54 in that he personally examined each case. On the other hand, psychological tests, apparently lacking for Dr. Cattell's series, were carried out in each instance. Of this group, 70% were diagnosed as character neuroses and 15% as ambulatory schizophrenics. The psychologist's diagnoses for the same group were 43% psychoneuroses, 31% character neuroses, and 22% schizophrenics. These figures support Dr. Cattell's findings of a much larger number of seriously sick individuals than has been recognized.

In an unpublished paper read at the American Orthopsychiatric Association meeting in 1952, Dr. Stephen Fleck and co-workers described a study of 100 unmarried mothers in a maternity shelter. Dr. Fleck's psychiatric classification is not readily comparable with the Cattell or Rabinovich studies because of his use of different diagnostic categories and because he considered that the condition of only 18 of the 100 cases warranted definite psychiatric classification. Of these 18, 5 were schizophrenic but none required hospitalization before or after delivery.

Some other comparisons with Dr. Cattell's material might be made with the 91 cases referred to earlier. In the experience of this agency the desire to keep the baby was also found more frequently among the sicker girls. Although a large number of the unmarried mothers in this series resisted help, the staff has estimated that at least 25% could use some form of psychotherapy or intensive casework. Many of us feel that improved coordination of diversified social and psychological services for unmarried mothers can significantly increase the number regarded as treatable in the broad sense. In general, the major responsibility for services to unmarried mothers is appropriately borne by social workers. In the social agency the psychiatrist functions in an adjunctive capacity, requiring a readjustment from his accustomed role of top responsibility. Dr. Cattell's experience illustrates fruitful integration of dynamic psychiatry and social work for the study and treatment of maladjustment expressed through unwed motherhood.

COMFORT, EFFECTIVENESS, AND SELF-AWARENESS AS CRITERIA OF IMPROVEMENT IN PSYCHOTHERAPY [1, 2]

MORRIS B. PARLOFF, PH. D., HERBERT C. KELMAN, PH. D., AND JEROME D. FRANK, M. D.

I

There is no more urgent problem facing psychiatry today than the evaluation of the effectiveness of psychotherapy. It is estimated that at least 9,000,000 Americans are suffering from some form of mental illness (25, p. 125). Many of these receive psychotherapy and many more feel that if only they could get it they would be relieved. As the approximately 10,000 psychiatrists, clinical psychologists, and psychiatric social workers in this country cannot begin to satisfy the demand, public and private agencies are supporting vast training programs requiring large investments of time and money. Society has a very large stake in psychotherapy but can be expected to continue support at present levels only if the results prove to be worth the cost.

In the face of this situation the unpleasant truth is that there is no agreement as to what kind of psychotherapy is best for different patients or psychiatric disorders, and the value of any type of psychotherapy remains to be conclusively demonstrated. At present the type of treatment received by a patient is largely determined by the accident of training of the therapist to whom he happens to go. Each therapist is confident that he is helping at least some of his patients. He can see them gain an understanding of their difficulties, lose their symptoms, and become more effective in their personal relationships. His successful patients are sure he has helped them and do not hesitate to sing his praise and refer their friends. Therapists tend to attribute failures to the patient's not being ready for therapy, or to a breach of technique. Failures seldom cause the therapist to question the aims or methods of his form of therapy.

Statistical studies of the results of psychotherapy, however, all show about two-thirds of the patients, plus or minus about 10%, as improved regardless of the type of therapy (1, 16). Moreover, the same improvement figure crops up with methods of treatment that are considered by their proponents to involve little if any psychotherapy, such as carbon dioxide treatment (7). What does this mean? The cynic may say that it probably represents the improvement rate that occurs over a period of several months as a result of ordinary life experiences or the spontaneous mobilization of the patient's recuperative forces. Those who accept such an interpretation might conclude that psychotherapists make their living off the spontaneous remission rate. Yet every psychotherapist has had patients whose improvement followed so closely upon occurrences in the therapeutic situation as to make it highly unlikely that this was due to mere chance.

In the present state of knowledge interpretation of these statistical findings is impossible. It is not even clear, for example, to what extent the consistency of improvement rates represents actual changes in the patients and to what extent they reflect a habit of mind of the judges. We do not know in what ways patients said to improve under different therapies resemble or differ from each other, or how to compare the techniques of different therapies and the nature of the results obtained.

These and many other questions must be clarified if psychotherapy is to become a science in the sense that different psychotherapies can be adequately described, their relative effectiveness convincingly demonstrated, and the type of therapy tailored to the personality of the patient and the nature of his disorder. To achieve these goals we must be able (1) to describe therapeutic techniques

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

[2] The research on which this paper is based was supported by a grant from the National Institute of Mental Health of the National Institutes of Health, U. S. Public Health Service. Dr. Kelman was a Public Health Service research fellow of the National Institute of Mental Health while collaborating on this paper.

in such terms that others can perform them similarly(4); (2) to describe the personality of the therapist as it relates to his influence on different types of patients(11, 19); (3) to describe patients in terms relevant for psychotherapy(6, 8); and (4) to describe improvement in terms permitting comparison of one type of therapy with another.

The problem of describing improvement has become one of concern to us in connection with a current study of attributes which influence the response to therapy of outpatients in a psychiatric clinic. For this study it was necessary to devise measures of improvement which made possible comparison of the results of 3 different types of therapy with a wide range of patients. This paper describes the measures selected, the considerations which led to their choice, and problems connected with their use. We believe that it is possible to measure the effects of therapy by means of a limited number of criteria, based on the patient's conscious, reportable feelings and overt behavior, which can be quantified, thereby allowing comparison of the effects of one therapy with another, and which at the same time are relevant to what is generally meant by improvement. The criteria proposed are comfort, effectiveness, and self-awareness.

II

Most of the accumulated literature on therapy is so difficult to evaluate because improvement is thought of in global terms and rated only with respect to degree. The fatal flaw in this procedure, as is now rather generally recognized, is that it assumes improvement to be a unitary phenomenon. All criteria of improvement are assumed to vary together, so that regardless of the specific criterion selected the results would be the same. This assumption probably does hold for patients who are markedly improved or recovered. Therapists of different schools, despite differences in their implicit or explicit criteria, agree readily as to the improvement of these patients, suggesting that the criteria have changed together.

With lesser degrees of improvement, however, the assumption that all criteria vary together is at best questionable and very likely false. It is probable that measures of different criteria of improvement would be affected differently depending on such factors as: (1) *The type of therapy.* For example, group therapy may tend to increase a patient's social facility more than his understanding of the historical origins of his interpersonal difficulties; certain kinds of individual therapy, on the other hand, may tend to increase the patient's insight without increasing his social facility. (2) *The type of patient.* Different individuals may have differential predispositions to change. Some may change readily with respect to symptoms and slowly as regards insight, while others may have opposite tendencies. Also, different persons may have differential need for change. One patient may be "sick" symptomatically, but functioning adequately in his social relations, while another may have his difficulties in the latter area. Successful therapy for the first patient would involve chiefly change in symptoms; for the second, improvement in his social relations. Finally, there may also be individual differences in the extent to which changes on the different criteria converge(17). (3) *Time.* Measures of some criteria may show change early in therapy but remain unaffected thereafter. Other criteria may show no change, or perhaps even worsen, during the early period but begin to change after further treatment. For example, the greater part of symptomatic relief may occur early in therapy; whatever symptoms survive the early treatment period may be extremely resistant to change. On the other hand, anxiety may increase early in therapy and decline later. The conditions under which different criteria of improvement are or are not positively correlated thus become a matter for empirical study.

If improvement is not a unitary phenomenon, over-all evaluations have serious drawbacks. Different evaluators may mean different things by improvement and the same evaluator may shift his criterion from one patient to the next. He may call one patient improved because his headaches are better and another improved because he has found a better job. Depending on the patient's original level, he may consider a given change, such as loss of a symptom, "slight

improvement" in one case and "great improvement" in another. The same change may be considered to represent improvement in one patient and worsening in another. Increased anxiety, for example, might be taken as a sign of improvement in an obsessional neurotic but a danger signal in an incipient schizophrenic.

The problem is most sharply emphasized by the patient who moves in opposite directions at the same time. For example, how is the over-all improvement to be rated in a woman who stops having migraine when she leaves her husband and gets it back when she resumes her role as housewife and mother?

Parenthetically, leaving "improvement" undefined probably facilitates overestimation of improvement. In the course of several months any patient is apt to change in some way whether or not he is receiving therapy, and the rater can usually find some positive change when he is looking for it and no restrictions are put on his choice. The study of Teuber and Powers(23) strikingly illustrates the danger of relying solely on therapists' estimates of improvement unchecked by an objective criterion. Although therapists of predelinquent boys believed about two-thirds of the children had "substantially benefited" from the treatment, no significant difference in number of court appearances was found between the treated boys and an untreated control group.

In short, global ratings of improvement tell nothing about the nature of the change produced by the therapy in question. They therefore contribute little to our understanding and, above all, do not permit comparison of the effects of one therapy with another. It means little to conclude that therapy *A* is better than therapy *B* because the results of therapy *A* show 90% improved and those of therapy *B* 60% improved, when these percentages really mean that in therapy *A* 90% of the patients lose their somatic symptoms and that after exposure to therapy *B* 60% of the patients get along better with other people. We agree with others(17, 20) that from a research point of view the effort to obtain over-all evaluations of improvement leads up a blind alley.

To illustrate the probable nonunitary nature of improvement, an example may be given from data of a preliminary study of 16 neurotic patients who were evaluated before and after 20 weeks of group therapy. Certain relationships among 4 of the many measures studied will be considered here. The measures are:

1. A symptom check list, filled out by the patient, which contained items pertaining chiefly to bodily distress and emotional disturbances.

2. A rating scale of the patient's discomfort, filled out by the staff and containing such items as sexual conflicts, social uneasiness, feelings of being exploited by others.

3. A measure of self-acceptance obtained by having a patient describe his behavior in the group by means of a Q-sort technique, and then, by re-sorting the items, describe what he would like his behavior to be(19). The degree of correlation between the two sorts was taken as a measure of self-acceptance.

4. A measure of the accuracy of the patient's description of his own behavior (self-awareness), obtained with the same Q-sort by correlating the patient's description of his own group behavior with that made by a trained observer. The higher the correlation, the more self-aware the patient was considered to be.

Certain correlations among these measures at the start of treatment, and among their degrees of change after treatment, are given in Table 1. (All omitted correlations did not differ significantly from zero.)

The fact that the staff's estimate of discomfort and the patient's own report of his symptoms tended to be positively correlated

TABLE 1

CORRELATIONS BETWEEN CERTAIN MEASURES OF IMPROVEMENT

Measures	Correlation Coefficients (r)	
	Before therapy	Amt. of change under therapy
Patient's symptoms and staff's estimate of his discomfort	.45 *	.44 *
Patient's symptoms and lack of self-acceptance	.51 †	.14
Patient's symptoms and lack of self-awareness	—.12	.53 †

* p less than .10.
† p less than .05.

to start with and to vary together under treatment suggests that they were to some extent measures of the same thing. This finding led us to abandon the former measure in subsequent research and to rely solely on the patients' own ratings as a measure of comfort(16).

That patients' symptoms and lack of self-acceptance are correlated at the start of treatment bears out the hypothesis that failure to accept oneself contributes to feelings of discomfort(13). Despite this initial relationship the two measures do not vary together under the conditions of therapy in this study.

Finally, that the severity of symptoms is not correlated with the patient's lack of self-awareness initially is in keeping with the general clinical observation that severity of symptoms and degree of self-awareness are not directly related. On the other hand, the correlation of decrease of symptoms with increase in self-awareness is consistent with the supposition that as patients get more comfortable they can dare to see themselves more accurately.

III

If improvement is not a unitary phenomenon, the problem at once arises as to how to select criteria for measuring the effects of therapy. Ideally, in order to determine the effectiveness of any form of therapy we should know the conditions giving rise to the illness it purports to treat and then determine the extent to which the therapy modifies or eliminates these conditions. The causes of psychiatric illness are so varied, complex, and poorly understood that this approach is not practicable at present.

Fortunately the effectiveness of different forms of therapy can be compared, regardless of the means used to bring improvement about, if a consensus can be reached as to what the baseline is from which improvement is to be measured, and what criteria of improvement will be used. Patients may change in any number of ways while undergoing therapy. Which of these changes shall be called improvement depends on value judgments as to the goals of therapy and these rest on value judgments as to the nature of mental health. The range of therapies and patients to which a given criterion of improvement can be applied depends on how widely held and generally applicable the values are on which it is based(12, 17).

With respect to the baseline from which improvement is measured, 3 possibilities are the patient's level at the beginning of treatment, his highest level of functioning prior to treatment, and the highest level of which he is capable. All are legitimate depending on what the goals of therapy are, but we have no hesitation in selecting the first as being the most widely used, as well as the easiest to handle.

Our criteria of improvement are based on the values of persons most concerned with the outcome of psychotherapy—the patient himself, his associates, and his therapist. It is safe to say that every patient seeks to gain from therapy more comfort in his daily functioning. Those with whom he interacts are apt to be less concerned with how well he feels than his effectiveness as a social being. Comfort and effectiveness have therefore been selected as the major criteria of improvement. Since increase in the patient's comfort and effectiveness are the goals of all the healing arts, we assume that these criteria are also acceptable to all psychotherapists. Many schools have an additional therapeutic goal, namely, increase in self-understanding. We have therefore included a measure of self-awareness as a criterion of improvement. Since self-awareness is of a different order than comfort and effectiveness it will be considered separately.

Before we describe the measures selected for comfort and effectiveness, it must be pointed out that the criteria can be measured in any number of ways, and changes in different measures of the same criterion are not necessarily positively correlated. For example, two possible measures of the criterion "comfort" are the discomfort-relief quotient (5), and a symptom checklist. For some patients, early in therapy, symptoms may be reduced, yet discomfort in terms of the discomfort-relief quotient increases. The two measures would thus show contradictory trends though both are reasonable measures of comfort.

The measures we have selected represent only one possible operational definition of

each of the criteria. They seem to have a face validity, that is, they are obviously related to the criterion they are supposed to define. The extent to which other measures of the same criteria would yield similar results, however, would have to be determined by further research.

In choosing measures of comfort, it became obvious that since this is a subjective state no one can judge it but the patient. It seemed wise to construct the chief measure of this criterion in terms not of comfort but its opposite—discomfort—since almost all clinic outpatients seek treatment to be relieved of distress, rather than to be helped to move from a satisfactory state of comfort to a better one. Accordingly our major measure of this criterion is a check list of distressing symptoms based on the Cornell Index. Each symptom is rated on a 4-point scale of severity. Since this scale does not provide for changes in the direction of positive comfort (as contrasted to diminution of discomfort) we are also using one modified from Lorr (15), containing 12 items chiefly concerned with the patient's feelings about various aspects of his interpersonal functioning. Each is rated on a 6-point scale ranging from the healthy, satisfying end of the continuum to the distressing one. For example, one scale ranges from "nearly always felt adequate" to "nearly always felt inferior;" another from "saw associates as almost always friendly" to "almost always antagonistic."

To test the reliability of this measure and the symptom check list, over one-third of the items were rewritten in alternate form. The average correlation between the original items and their equivalent forms was 0.74.

Total scores as well as individual items are used to evaluate improvement. The use of a total score circumvents the objection of functional equivalence of symptoms which is urged against the use of symptoms as a measure of improvement; that is, if a patient gives up one symptom he may develop another to replace it. The total score would show improvement only if there were a net decline in number and intensity of all symptoms. If a patient replaces distressing headaches with equally distressing stomach aches, his total score will remain unchanged.

The problem of rating effectiveness posed more difficulties. As with comfort, it seemed wisest to try to measure the degree to which the patient fell short of satisfactory functioning rather than the extent to which he exceeded it, so that the scale actually measures ineffectiveness. Fifteen categories were selected, the first 7 representing "active" modes of social ineffectiveness, the next 7 their "passive" counterparts, while the fifteenth was sexual adjustment. The 7 pairs of categories are: overindependent—overdependent; superficially sociable—withdrawn; extrapunitive—intrapunitive; officious—irresponsible; impulsive—overcautious; hyperreactive—constrained; and oversystematic—unsystematic.

On the basis of material obtained from an interview with the patient and with another informant who knows him well (usually a close relative) the degree of ineffectiveness in each category is rated on a 5-point scale. The rating is determined by the degree of inappropriateness of the behavior and its frequency. In arriving at each rating the degree of the ineffectiveness of the patient's behavior is first rated separately with respect to various significant people in his life. These persons are grouped under 5 headings—own family, marital family, occupation, social activities, and interviewer. It should be noted that this procedure takes account of the fact that degree and form of a patient's ineffectiveness are closely related to the situations in which he finds himself. A patient may on this scale obtain fairly high scores on opposed modes of ineffectiveness with different significant persons. For example, he may be intrapunitive with his mother but extrapunitive with his wife, withdrawn from work associates but superficially sociable with tavern acquaintances, and so on. A final single rating for each category is obtained by using the ratings for each of the 5 headings as a guide but taking into consideration also the relative importance to the patient of the persons with whom the ineffective behavior was shown and the number of persons involved. Despite the inferential nature of these ratings they were found to have adequately high interjudge reliability. The average intercorrelation of 4 judges was 0.69, and the average difference between their ratings was only six-tenths of a scale unit.

IV

Since our measures are based exclusively on rating scales, certain questions and problems connected with the use of this tool must be considered. It may be attacked in principle on the grounds that results of therapy are not amenable to measurement because it is a highly personal relationship differing for each patient and therapist and involving emergent rather than static situations(2). According to this view the infinite variety and subtlety of patients' feelings in therapy cannot be adequately comprehended by rating scales or any other limited objective measures. It is claimed that only the intuitive judgment of the therapist, untrammeled by the chains of scientific method, can properly evaluate his patient's unique therapeutic experience(10).

We grant that certain gifted therapists might be excellent judges of the results of therapy on their patients. Such judgments, however, afford no basis for developing a science of psychotherapy. If the basis for a judgment cannot be made explicit, real advance in knowledge is not possible(3). Every clinical judgment, however intuitive, is implicitly a statistical judgment, because in making it the clinician is comparing his present patient with all the other patients he happens to remember. That is, he is actually using statistical techniques but in a subjective and uncontrolled way. Actually, some evidence suggests that highly circumscribed statistical data may be superior to the intuitive clinical approach in making prognoses, which is analogous to evaluating improvement(21). Kelley(14), for example, found that the Strong Vocational Interest Test consistently predicted over-all competence in clinical psychology better than any other predictive measure including pooled clinical judgments.

We believe that the implicitly statistical nature of clinical judgments should be made explicit and that they can be objectified and quantified. Rating scales achieve both these ends. Judgments on rating scales are clinical judgments, in the sense that they are arrived at after consideration of many imponderable variables which may differ from case to case and which cannot be precisely formulated. They are an improvement over crude clinical judgments in that they tend to make them more accurate and more comparable. They do the former by breaking the over-all judgment down into subcategories which serve as checks on each other; the latter by forcing all the judges to use the same terms regardless of the particular patient and therapy involved. The use of rating scales does, indeed, lose nuances of feeling and behavior, and a given set of scales may prove to have omitted the very phenomena that most require study. If this is the case, however, the answer is not to abandon the method but to develop rating scales to fill the gaps.

The scores on our scales represent either direct judgments by the patient or judgments by staff members. The latter are based on 3 sources of data: what the patient says about himself, the limited segment of his behavior observable in the interview, and a relative's report. The limitations and sources of error inherent in such data have been well described by Mosak(18). The patient's reports are subject to 2 sources of error which may be termed attentional and motivational. From the standpoint of attention, with the best will in the world it is difficult to introspect one's feelings accurately or to give an undistorted report of past experiences, especially for a person inexperienced in doing this. From the standpoint of motivation, the patient's reports are influenced by his fears and hopes and by his relationship to the interviewer. An example of the former is the patient whose toothache disappears while he sits in the dentist's waiting room. Another is the patient whose fear of heart disease intensifies his distress from cardiac symptoms. The patient's relationship with the interviewer may lead him, for example, to exaggerate his difficulties in order to convince the interviewer he needs help, or minimize them, especially after a period of treatment, to please the interviewer by showing how effective treatment has been. Initially, distrust of the interviewer may lead him to conceal, consciously or unconsciously, certain difficulties which he reveals as he becomes more secure, so that he may appear sicker when he is actually improving. Certain patients cannot admit the existence of a problem to someone else, or sometimes even to themselves, until they have at least partly overcome it. So in a final interview one may learn for the first

time of a difficulty that was present from the beginning. Thus changes in ratings after a period of therapy might be due to a change not in how the patient actually felt or saw his behavior but in what he was able or willing to report about himself.

Raters are vulnerable to the same type of attentional and motivational errors as the patient, usually because of a desire to see improvement. For them, however, the errors are apt to be less severe, both because of their training and because they are not as deeply involved emotionally.

While these sources of error cannot be completely eliminated certain steps were taken to minimize them. Many different sources of data—interview material, direct observations of behavior, interviews with relatives—made it possible to check the findings from different sources against each other. The patient's description of his behavior at home was evaluated with respect to some of its aspects by reference to a relative's report, as well as by the observation of the patient's facial expressions, posture, and tone of voice. The latter also served as a check on his description of his feelings.

Finally, we believe that the accuracy of the clinical judgment of any one rater can be heightened by a conference among the different raters. Ratings based on a conference may have certain disadvantages, among them the danger that a member of the group with more prestige than the others, say the senior psychiatrist, may unduly influence the final ratings. This danger is greatly reduced if all the conferees are aware of it. It is further minimized by having each member make his own ratings before coming to the conference. Whatever the drawbacks in the conference method, they are more than counterbalanced by the opportunity given each participant to reevaluate his impressions in the light of new information or differences in emphasis supplied by the other members.

V

Comfort and effectiveness are criteria of improvement based on values generally held by patients, the persons with whom they customarily interact, and psychotherapists. Psychotherapists are inclined to judge the effects of therapy by reference to additional values based on their theories of personality. We therefore include a criterion derived from certain prevalent views of personality and have studied its relation to changes in comfort and effectiveness. This we term self-awareness.

It is often claimed that changes in conscious distress and overt behavior are superficial and of little significance unless accompanied by changes assumed to be more fundamental, such as increased self-understanding, modification of underlying attitudes, improved integration, making the unconscious conscious, and making the patient's potential energy available to him(26). While such concepts are needed in thinking about the goals and processes of therapy, they are useful for research only to the extent that they can be defined operationally, measured reliably, and clearly related to generally accepted criteria of improvement.

Statements that a patient has undergone a reorganization of personality, or their equivalent, may be defined from an operational standpoint in at least 3 ways. (1) They may mean that the patient has come to express attitudes more highly approved by the therapist than those expressed at the start of treatment. To take an extreme example, some therapists say that even if a patient fails to improve symptomatically, his treatment is worthwhile because it makes him more insightful or tolerant. Operationally this means merely that he has become closer to what the therapist considers a mentally healthy person. Sometimes this implies that the patient has become more like the therapist; probably more often it means that he has become more like what the therapist would like to be(22). Basic personality change in this sense is equivalent to accepting the therapist's value system, at least in part, and is closely analogous to being converted to a religious faith. That this may be a powerful therapeutic experience is recognized. Questions as to the conditions under which a patient's values approach those of the therapist and the extent to which this is related to improvement in comfort and effectiveness, are beyond the scope of this paper.

(2) Statements as to the occurrence of deeper personality changes may be hypotheses as to the means by which improvement

in comfort and effectiveness was brought about. Thus it may be said that a patient has become more comfortable and effective because he has gained insight. Two methodological difficulties with this view are that there are no unequivocal tests of deeper personality changes and the relationship of such changes to the goals of therapy remains unclear. Projective tests(9) and indices of autonomic activity(24), as possible measures of personality change, promise to shed much light on the psychotherapeutic process, but present great difficulties in interpretation. Neither is it possible at present to relate surmised personality changes to changes in comfort or effectiveness. One judge might conclude that a certain patient had undergone a significant personality reorganization because the quality of his work had improved, another that he had not because his relationship with his wife was no better.

(3) Statements as to personality change are prognostic statements about the likelihood that improvement will be maintained after therapy stops. To say that a patient has undergone a favorable reorganization of attitudes is to imply that he will be able to handle future stresses more effectively. Such prognoses in principle are amenable to experimental attack by means of follow-up studies, though these involve a formidable methodological problem—how to compare the severity of situational stresses at the time of the follow-up with those prior to treatment. The problem is complicated by frequent difficulty in determining the extent to which changes in situational stresses are independent of treatment or caused by it.

Parenthetically, the importance of temporary improvement should not be underestimated. The fact that a diabetic, brought out of coma by insulin, will relapse if the insulin is discontinued, does not mean that insulin is to be dismissed as affording merely temporary relief. Transient symptomatic improvement with shock treatment has saved many a depressed patient from suicide.

One goal of therapy, formulated in terms of underlying personality change, is so widely held that we are including a measure of one aspect of this goal and are studying how it varies with comfort and effectiveness. This goal may be summed up by the Socratic dictum "know thyself." Increased understanding of oneself and the nature of one's illness is an important objective of treatment in all chronic illness, on the assumption that the better the patient understands his condition the better he can care for himself. Analogously, all uncovering, exploratory or client-centered methods of psychotherapy, as well as those based on learning theory, include in their goal gain in self-awareness. The implication is that the more completely and accurately a patient knows himself, the more free he will be of subjection to inner compulsions and outer pressures and the better able to meet the stresses of life.

Accuracy and completeness of self-awareness may well be a culturally determined goal, limited largely to the intellectually oriented segment of the population(27). Many persons make marked strides in comfort and effectiveness by forcibly directing their attention away from themselves to the outside world. Others are greatly helped by embracing illusion and submerging themselves in a cult. Moreover, it is unlikely that any psychotherapist would consider increase in self-understanding to be a desirable goal for all types of patients. Older persons with depressive tendencies, for example, may need to strengthen their favorable illusions about themselves rather than learn to appraise themselves with cold objectivity. Such an appraisal may reveal their inadequacies all too clearly at a time of life when not much can be done about them. Nevertheless, the concept of self-awareness underlies so much thinking about the goals and processes of psychotherapy that some attempt to measure changes in this criterion seems worthwhile. We have fallen back on a very simple device which attempts to measure the patient's ability to appraise accurately his own behavior in the interview. This is only a small aspect of self-awareness, to be sure. Whether it will prove a significant one, studies now under way will tell. An interview with the patient is observed through a one-way screen. At the close of the interview both patient and observer rate the patient's behavior in terms of a check list containing 13 adjectives descriptive of behavior: alert, shy, stubborn, annoyed, relaxed, friendly, polite, honest, restrained, overtalkative, inconsistent, fright-

ened, and cautious. Some of these also refer to feelings. The extent to which each adjective applied to the patient in the interview, ranging from "not like I behaved" to "very much like I behaved," is rated on a 4-point scale.

The observer's rating is accepted as the accurate one, an assumption which seems justified on *a priori* grounds as well as by the high reliability of independent ratings by 2 observers ($r = .88$). The accuracy of the patient's perception of his own behavior towards the interviewer is given by the agreement between his ratings and those of the observer.

Summary

Since improvement under psychotherapy is not a unitary phenomenon, progress in studying the effectiveness of psychotherapy depends on the use of carefully defined and generally agreed upon criteria of improvement. In the present state of knowledge such criteria must be based on value judgments by the patient, and by persons with whom he interacts. It is suggested that the criteria comfort and effectiveness represent these values. Means of measuring them are described and problems connected with the measures considered. Some implications of the viewpoint that improvement must be evaluated in terms of underlying personality changes are discussed. A simple measure of self-awareness is described which may be a possible indicator of certain such changes.

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DISCUSSION

Joan Fleming, M. D., Chicago, Ill.—With several basic assumptions as stated in the paper, I would agree that improvement is not a unitary phenomenon and that the goals of therapy vary with the patient and with the therapist. However, there are certain assumptions implicit in the paper with which I would not agree. There is a strong tendency to treat "a type of psychotherapy" as if it were an entity [in omitted paragraphs]. A plea is made for efforts toward adequate descriptions of "type of psychotherapies" in order to differentiate one from another for the purpose of testing each separately. There is also the implicit assumption that a "type of psychotherapy" is something "done to" the patient. It is hard for me to believe that the authors believe this. Therefore I would suggest that they pay some attention to this possible interpretation of their work. For, with this implication, many of their other statements are belied and their paper seems to become concerned with an argument for measuring "types of psychotherapy."

Another result of this implicit assumption is to seem to measure the effects of psychotherapy as separated from the effect of the patient's own restorative powers. The authors quote the figure that about ⅔ of patients show improvement regardless of the therapeutic procedure.

I am not defending any type of psychotherapy. In my opinion, psychotherapy of any type acts only as a catalytic agent in the natural drive toward the restoration of a functioning equilibrium. This equilibrium may be more or less healthy in terms of social values but it is an expression of the patient's adaptive capacities.

It seems to me the emphasis in this paper on criteria for evaluating different types of psychotherapy is premature when the description of the process of psychotherapy is so inadequately described at present. This basic study must deal first with our language which is extremely deficient in words to describe, let alone explain, the processes of inter- and intrapersonal communication. The authors, I am sure, felt this deficiency when they tried to make up the rating scales used to test their criteria.

My personal orientation is toward psychoanalytic psychology, which the authors seem to attribute to the group who consider self-understanding as an important measure of improvement. Certainly, this is not a goal in itself in spite of the interpretation of what Socrates said. Socrates lived so long before Freud that he never heard the famous story of the American who spent 2 years in Europe undergoing a certain type of psychotherapy. This "improved" patient was met at the boat by his friends eager to see the results. "Well, I still stutter," he said, "but I know why."

Many questions could be asked regarding minor points in the paper. On the whole, the authors demonstrate an awareness of the complications, objections, and sources of error in their work. Reading the paper left me with a feeling of disappointment and of hope: disappointment that the presentation omitted so much of the clinical data and especially that such short shrift was given to "self-understanding." There was a disappointment that so much emphasis was given to evaluation of "types of psychotherapy."

My hope is for continued study and publication with emphasis on the process of psychotherapy, whatever the procedure, the goals, or the psychological systems of the therapist.

CLOSING DISCUSSION

Jerome D. Frank, M. D., Baltimore, Md.—We share Dr. Fleming's opinion that the decisive factor in producing improvement lies more in the patients' restorative powers than in the form of psychotherapy used, and have started research projects to evaluate attributes influencing their response to psychotherapy. But different schools of psychotherapy do exist, each of which claims special virtues. Before trying to define their processes in more detail we must determine whether their effects really are different. If not, there is little point in trying to describe them more precisely. A prerequisite for studying differences in both responsiveness of patients and effectiveness of therapies is the development of measures of improvement by which all neurotic patients and all forms of psychotherapy can be compared, which is what we have tried to do.

SOME PROGNOSTIC FACTORS IN 538 TRANSORBITAL LOBOTOMY CASES

C. L. JACKSON, M.D.,[1] RUSK, TEX., AND E. GARTLY JACO, PH.D.,[2] AUSTIN, TEX.

This study represents an attempt to determine statistically an array of specific factors significantly associated with improvement or successful outcome and unimprovement or failure in 538 patients who have had transorbital lobotomy following unsuccessful outcome of other common treatment methods.[3] Freeman's pioneer work(1, 2) in transorbital lobotomy, the Boston studies in lobotomy under Greenblatt(3), and certain aspects of the Columbia-Greystone project as discussed by Mettler(4) have been helpful in providing hypotheses and pointing out many factors leading toward a more precise evaluation of lobotomy in general and transorbital lobotomy in particular. This paper, although not exhaustive, reports the significance or lack of significance of many psychiatric and sociologic factors, suggested or implied by these studies, contingent upon improvement or unimprovement 1 to 4 years following transorbital lobotomy.

Following each transorbital lobotomy, the patient was classified as improved, unimproved, or worse, such evaluation being the consensus of the neurosurgeon, ward physicians, nurses, and attendants. Of the 538 cases, only 13 were evaluated as being worse. Since this sum was too small for statistical analysis, the category of "worse" was combined with that of "unimproved," leaving 2 groups—improved and unimproved. The statistical null hypothesis that no significant difference existed between the improved and unimproved groups was then tested for each factor by the chi-square test of significance. The strength of contingency between the significant factors and outcome of the operation was then tested by corrected contingency coefficients.

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[3] Acknowledgment is due Richard L. Neel for his assistance in gathering the data.

SIGNIFICANT FACTORS

The following factors were found to be significantly different between the improved and unimproved groups.

General Improvement.—Of the 538 patients, 307 (57%) were improved while 231 (43%) were unimproved (P=.01). Ten fatalities (2%) occurred while no other disabilities were apparent. Fifty-three percent were able to leave the hospital following transorbital lobotomy, including 78% of the improved and 19% of the unimproved groups. Of this group leaving the hospital, 53% later returned, while at present, out of the total group of lobotomy patients, 31% are still out of hospital. Of the improved group, 52% are now out of hospital while 96% of the unimproved group are at present still in hospital. It seems pertinent to point out that, since the median length of illness for the entire group was 5 to 9 years and the median duration of hospitalization was 2 to 4 years, this further indicates favorable results of transorbital lobotomy, as the likelihood of discharge from the hospital after one or more years of hospitalization is considerably less.

Sex.—Female patients showed a higher percentage of improvement than the males (P=.001). Sixty-seven percent of the females improved while only 41% of the males did so (Table 1).

Color.—Between white and Negro patients, the latter group was significantly more improved (P=.001), 67% of the negroes compared with 51% of the whites. Only 3 Mexican cases received transorbital lobotomy,

TABLE 1

SEX DIFFERENCES BETWEEN 538 IMPROVED AND UNIMPROVED TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Sex	N	%	N	%	N	%
Male.....	84	.41	123	.59	207	.38
Female...	223	.67	108	.33	331	.62
Totals...	307	.57	231	.43	538	1.00

* Chi-square = 37.05; p<.001.
C = .36.

with 1 improving and 2 not, but this sum was too small for inclusion in the statistical analysis (Table 2).

Diagnosis.—Involutional, paranoid, and mixed schizophrenic patients had higher percentages of improvement than expected while psychoses with meningoencephalitis, convulsive disorders, and mental deficiency cases had lower frequencies of improvement than expected (P=.001) (Table 3).

Duration of Illness.—The shorter the duration of illness, the greater is the likelihood of improvement (P=.05). Less than 4 years' duration showed the greatest improvement while over 10 years decreased chances of improvement sharply (Table 4).

Duration of Hospitalization.—This factor was of greater significance than duration of illness, although the general pattern was similar; the shorter time hospitalized, the greater chance for improvement (P=.001). The period for improvement, however, is shorter than that for duration of illness: the maximum for improvement is less than 2 years and under 1 year hospitalization the probability is considerably greater; more than 2 years of hospitalization decreases chances for improvement (Table 5).

Electric Shock Therapy.—Patients receiving no more than 10 electric shock treatments showed greater improvement than those receiving a greater number (P=.05). The group having more than 70 shocks showed the least improvement. Although the trend is not entirely consistent, generally the greater the amount of electric shock treatment, the less likely are the chances for improvement. It should also be pointed out that, since 21% of the patients were omitted

TABLE 2

COLOR AND IMPROVEMENT AND UNIMPROVEMENT IN 535 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Color	N	%	N	%	N	%
White...	161	.51	156	.49	317	.59
Negro...	145	.67	73	.33	218	.41
Totals...	306	.57	229	.43	535	1.00

* Chi-square = 13.40; p<.001.
$\overline{C}$ = .22.

TABLE 4

DURATION OF ILLNESS AND IMPROVEMENT AND UNIMPROVEMENT IN 532 TRANSORBITAL LOBOTOMY CASES *

Duration of	Improved		Unimproved		Totals	
illness	N	%	N	%	N	%
Up to 180 days..	10	.63	6	.37	16	.03
181-365 days	17	.74	6	.26	23	.04
1-2 years	34	.76	11	.24	45	.08
2-4 years	69	.60	46	.40	115	.22
5-9 years	68	.58	50	.42	118	.22
10-14 years	45	.51	44	.49	89	.17
15-20 years	31	.46	36	.54	67	.13
Over 20 years...	29	.49	30	.51	59	.11
Totals	303	.57	229	.43	532	1.00

* Chi-square = 15.63; p < .05.
$\overline{C}$ = .18.

TABLE 3

DIAGNOSIS AND IMPROVEMENT AND UNIMPROVEMENT IN 521 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Diagnosis	N	%	N	%	N	%
Meningoencephalitic	8	.36	14	.64	22	.04
Cerebral arteriosclerosis	3	.50	3	.50	6	.01
Psychosis with convulsive disorders	2	.22	7	.78	9	.02
Involutional	14	.78	4	.22	18	.03
Manic-depressive, manic type	16	.57	12	.43	28	.05
Manic-depressive, depressed type	14	.52	13	.48	27	.05
Schizophrenia, simple	12	.46	14	.54	26	.05
Schizophrenia, hebephrenic type	39	.51	37	.49	76	.15
Schizophrenia, catatonic type	19	.50	19	.50	38	.07
Schizophrenia, paranoid type	93	.63	54	.37	147	.29
Schizophrenia, mixed type	52	.75	17	.25	69	.13
Schizophrenia, other	5	.45	6	.55	11	.02
Psychosis, undifferentiated	4	.80	1	.20	5	.01
Personality disorders	5	.63	3	.37	8	.02
Psychosis with mental deficiency	10	.32	21	.68	31	.06
Totals	295	.57	225	.43	521	1.00

* Chi-square = 37.82; p < .001.
$\overline{C}$ = .27.

from the analysis of this factor because their exact EST history was undetermined (records of some patients destroyed by fire), these results concerning EST should be regarded as tentative (Table 6).

Insulin Coma Therapy.—Patients having had no insulin treatment showed greater improvement than the insulin-treated group. While the pattern is erratic, generally the greater the number of insulin coma hours, the less the chance of improvement following transorbital lobotomy (P=.01) (Table 7).

Marital Status.—Data suitable for statistical analysis included 43% of the total number of patients receiving transorbital lobotomy. Married patients showed greater improvement than expected while single persons indicated less improvement than expected (P=.05) (Table 8).

Education.—Forty-five percent of the total subjects were included in the analysis of this factor. While no consistent relationship was found between the amount of education and outcome, specific levels of education were significant between the improved and unimproved groups (P=.01). In the improved group, higher frequencies than expected were found for those having 8, 9, and 11 to 12 years of schooling. For the unimproved group, those who were illiterate, or who had 6 and 10 years of education, were higher than expected. The amount of college education was not found to be significant, although 78% with college training failed to improve after transorbital lobotomy (Table 9).

Occupation.—Only a limited number of occupational classes were large enough to justify statistical analysis, rendering this factor of limited application in this study. Those in the service occupations and housewives showed greater improvement than the agricultural and unskilled laboring occupations (P=.05) (Table 10).

Church Affiliation.—In general, Protes-

TABLE 5

DURATION OF HOSPITALIZATION AND IMPROVEMENT AND UNIMPROVEMENT IN 533 TRANSORBITAL LOBOTOMY CASES *

Duration of	Improved		Unimproved		Totals	
Hospitalization	N	%	N	%	N	%
Under 180 days..	77	.73	29	.27	106	.20
181-365 days	38	.78	11	.22	49	.09
1-2 years	37	.61	24	.39	61	.11
2-4 years	44	.46	52	.54	96	.18
5-9 years	51	.49	53	.51	104	.20
10-14 years	23	.43	31	.57	54	.10
15-20 years	22	.63	13	.37	35	.07
Over 20 years...	12	.43	16	.57	28	.05
Totals	304	.57	229	.43	533	1.00

* Chi-square = 34.98; $p < .001$.
$\bar{C} = .27$.

TABLE 6

ELECTRIC SHOCK THERAPY AND IMPROVEMENT AND UNIMPROVEMENT IN 424 TRANSORBITAL LOBOTOMY CASES *

Number of	Improved		Unimproved		Totals	
E.S.T.'s	N	%	N	%	N	%
1-10	17	.77	5	.23	22	.05
11-14	10	.50	10	.50	20	.05
15-19	30	.60	20	.40	50	.12
20-24	25	.63	15	.37	40	.09
25-29	14	.54	12	.46	26	.06
30-39	17	.71	7	.29	24	.06
40-49	41	.58	30	.42	71	.17
50-70	54	.57	40	.43	94	.22
Over 70	30	.39	47	.61	77	.18
Totals	238	.56	186	.44	424	1.00

* Chi-square = 16.85; $p < .05$.
$C = .21$.

TABLE 7

INSULIN COMA THERAPY AND IMPROVEMENT AND UNIMPROVEMENT IN 528 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
I.C.T.'s	N	%	N	%	N	%
None	216	.63	127	.37	343	.65
1-6	3	.43	4	.57	7	.01
7-14	8	.73	3	.27	11	.02
15-19	9	.30	21	.70	30	.06
20-24	3	.37	5	.63	8	.02
25-29	6	.50	6	.50	12	.02
30-39	4	.67	2	.33	6	.01
40-49	3	.25	9	.75	12	.02
50-70	16	.50	16	.50	32	.06
Over 70	33	.49	34	.51	67	.13
Totals	301	.57	227	.43	528	1.00

* Chi-square = 26.13; $p < .01$.
$\bar{C} = .23$.

TABLE 8

MARITAL STATUS AND IMPROVEMENT AND UNIMPROVEMENT IN 234 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Marital status	N	%	N	%	N	%
Single	24	.26	70	.74	94	.40
Married	43	.46	50	.54	93	.40
Divorced	12	.43	16	.57	28	.12
Separated	7	.37	12	.63	19	.08
Totals	86	.37	148	.63	234	1.00

* Chi-square = 9.68; $p < .05$.
$\bar{C} = .23$.

tants showed greater improvement than Catholics; there were no Jewish patients in this group. Among specific denominations represented, Baptist and Methodist membership (prevalent in this particular region of the state) showed greatest improvement while Catholics and those having no known church affiliation indicated lowest improvement (P=.01) (Table 11).

Venereal History.—One of the unexpected findings was that those patients having a positive venereal disease history showed a significantly greater improvement following transorbital lobotomy than those having a negative history (P=.05). Seventy-three percent of the positive cases improved compared with 56% of the negative patients (Table 12).

Readmission Status.—Those having a readmission status either before or after transorbital lobotomy showed greater improvement than those never having been released from the hospital (P=.05) (Table 13).

TABLE 9

EDUCATION AND IMPROVEMENT AND UNIMPROVEMENT IN 240 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Education	N	%	N	%	N	%
Illiterate	3	.17	15	.83	18	.075
None to 3 years	8	.32	17	.68	25	.10
4-5 years	16	.36	28	.64	44	.18
6 years	4	.17	20	.83	24	.10
7 years	13	.36	23	.64	36	.15
8 years	11	.52	10	.48	21	.09
9 years	9	.60	6	.40	15	.06
10 years	4	.25	12	.75	16	.07
11-12 years	14	.61	9	.39	23	.10
College: 1 or more years	4	.22	14	.78	18	.075
Totals	86	.36	154	.64	240	1.000

* Chi-square = 22.46; $p < .01$.
$\bar{C} = .31$.

TABLE 10

OCCUPATIONAL CLASS AND IMPROVEMENT AND UNIMPROVEMENT IN 229 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Occupational class	N	%	N	%	N	%
Service	16	.50	16	.50	32	.14
Agricultural	10	.24	31	.76	41	.18
Unskilled labor	13	.28	34	.72	47	.20
Miscellaneous	34	.47	39	.53	73	.32
No occupation	10	.28	26	.72	36	.16
Totals	83	.36	146	.64	229	1.00

* Chi-square = 11.13; $p < .05$.
$\bar{C} = .24$.

INSIGNIFICANT FACTORS

The following factors, some of which have been considered significant in the prognosis of lobotomy by others, were found to be statistically insignificant in improvement or unimprovement in our transorbital lobotomy cases:

Age.—While age generally was not a discriminatory factor between improvement or unimprovement in transorbital lobotomy, the extreme age-groups, 15 to 19 and 65 to 69,

TABLE 11

CHURCH AFFILIATION AND IMPROVEMENT AND UNIMPROVEMENT IN 487 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Church affiliation	N	%	N	%	N	%
Baptist	129	.65	70	.35	199	.41
Catholic	13	.39	20	.61	33	.07
Church of Christ	15	.65	8	.35	23	.05
Methodist	36	.69	16	.31	52	.11
Presbyterian	5	.50	5	.50	10	.02
Holiness	5	.63	3	.37	8	.01
None	78	.48	84	.52	162	.33
Totals	281	.58	206	.42	487	1.00

* Chi-square = 18.94; $p < .01$.
$\bar{C} = .21$.

TABLE 12

VENEREAL HISTORY AND IMPROVEMENT AND UNIMPROVEMENT IN 526 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
V.D. history	N	%	N	%	N	%
Negative	269	.56	212	.44	481	.91
Positive	33	.73	12	.27	45	.09
Totals	302	.57	224	.43	526	1.00

* Chi-square = 4.67; $p < .05$.
$\bar{C} = .13$.

TABLE 13

READMISSION STATUS AND IMPROVEMENT AND UNIMPROVEMENT IN 520 TRANSORBITAL LOBOTOMY CASES *

	Improved		Unimproved		Totals	
Readmission status	N	%	N	%	N	%
None	189	.53	166	.47	355	.68
Before lobotomy	92	.65	49	.35	141	.27
After lobotomy	16	.67	8	.33	24	.05
Totals	297	.57	223	.43	520	1.00

* Chi-square = 6.78; $p < .05$.
$\bar{C} = .14$.

indicated the least likelihood of improvement; 67% of the former and 73% of the latter age-group failed to improve.

Onset of Illness.—Three types of onset of mental illness were determined: gradual, rapid, and insidious. In no instance did type of onset discriminate between improvement and lack of improvement, although rapid onset held a very slight edge over the other 2 types.

Suicidal Tendencies.—The presence or absence of suicidal tendencies among transorbital lobotomy patients failed to discriminate significantly between improvement and failure to improve.

Birth Order.—The order of birth of the patient in his family did not prove to be significantly related to improvement or unimprovement in transorbital lobotomy. The median of both improved and unimproved groups was the second order of birth.

Number of Siblings.—Another family factor, size, as measured by the number of siblings, was insignificant in improvement or lack of improvement. Patients with 10 or more siblings indicated the poorest prognosis.

Conclusions

Arnot, Talbot, and Greenblatt(3), have presented a profile of the theoretically ideal patient for improvement and for unimprovement in prefrontal lobotomy. Similarly, our findings suggest the following profiles for the ideal patient with good and poor prognosis in transorbital lobotomy, *its validity being confined to the range of patients included in the foregoing analysis:*

More Likely to Improve

1. Sex: female.
2. Color: Negro.
3. Diagnosis: involutional, or schizophrenic, mixed or paranoid types.
4. Duration of Illness: less than 2 years.
5. Duration of Hospitalization: less than 1 year.
6. Previous Treatment: less than 10 EST's.
7. Marital Status: married.
8. Education: 11-12 years.
9. Occupation: service occupations.
10. Church Affiliation: Protestant—Baptist or Methodist.
11. Venereal History: positive.
12. Readmission Status: present.

Less Likely to Improve

1. Sex: male.
2. Color: white.
3. Diagnosis: psychosis with mental deficiency, psychosis with convulsive disorders, or psychosis with meningoencephalitis.
4. Duration of Illness: 10 or more years.
5. Duration of Hospitalization: 2 or more years.
6. Previous Treatment: 15 or more ICT's, or over 70 EST's.
7. Marital Status: single.
8. Education: illiterate or 6 years.
9. Occupation: agriculture.
10. Church Affiliation: Catholic, or none.
11. Venereal History: negative.
12. Readmission Status: none.

Summary

A statistical analysis was made of the significance of 18 psychiatric and sociologic factors in improvement and unimprovement of 538 mental patients following transorbital lobotomy. The results indicated that 57% showed improvement while 43% failed to improve. Fatalities amounted to 2%. Fifty-three percent left the hospital following transorbital lobotomy with 31% still remaining out of the hospital to date.

Thirteen factors were found to significantly discriminate between improvement and unimprovement following transorbital lobotomy: sex, color, diagnosis, duration of illness, duration of hospitalization, number of electric shock treatments, number of insulin coma hours, marital status, education, occupational class, church affiliation, venereal history, and readmission status.

The remaining 5 factors found to be insignificant in improvement and unimprovement following transorbital lobotomy were: age, onset of illness, suicidal tendencies, birth order, and number of siblings of the patient.

Profiles of the theoretical patient more likely and less likely to improve following transorbital lobotomy are presented.

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INITIAL PSYCHIATRIC FINDINGS OF RECENTLY REPATRIATED PRISONERS OF WAR [1]

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INTRODUCTION

The circumstances surrounding the so-called "confessions" of Mindszenty, Oatis, and Voegeler suggested that the Communists were using psychiatric knowledge perversely to produce drastic changes in men's fundamental attitudes and beliefs. Knowledge of the Communist program of "Brain Washing" in Red China(1) further confirmed this opinion. For the first time, psychiatric principles and techniques were being utilized not constructively for the study, diagnosis, prophylaxis, and treatment of mental illness, but rather destructively in a deliberate, coldly calculated, highly systematized attempt to produce a state of mental aberration detrimental to the individual concerned and of value only to the Communists.

During the Korean conflict there were indications that Americans held prisoner by the enemy were being subjected to an intensive indoctrination program. It was proposed that a study of those prisoners at the time of repatriation to friendly hands might provide valuable preliminary information for the essential appraisal of the tactics, techniques, and effectiveness of Communist indoctrination efforts.

This paper is a résumé of the psychiatric planning, and modus operandi of Operations Little Switch and Big Switch. Reference will be made to the initial psychiatric findings and impressions in 149 repatriated United States military personnel evaluated in Tokyo during Operation Little Switch, and 1,551 Big Switch repatriates, including 1,301 evaluated at Inchon, Korea, and 250 sick and wounded evacuated to Tokyo. The enemy indoctrination program will be discussed in some detail. Such a study is objectively cross-sectional rather than conclusive. A continuing study of the entire problem is being carried out by the Army.

PLANNING

The Department of the Army prescribed minimum standards to be met in the examination of repatriates, including a complete medical and psychiatric evaluation. The medical literature contains many references to the effects of war imprisonment upon both the minds and bodies of men(2-15). The emphasis placed upon neurological and neurophysiological findings by many of those studies made them of limited value in planning an appraisal of Communist imprisonment and indoctrination. It was determined in the Far East Command that the psychiatric examination would consist of a psychiatric interview of at least 1 hour's duration, a complete psychological test battery and, where time permitted, a psychiatric social history.

This evaluation was necessary for several reasons. It was essential that repatriates suffering from serious psychiatric disorder be detected immediately and accorded psychiatric treatment. Moreover a careful psychiatric evaluation should be performed so that possible future claims arising from prisoner-of-war-connected disability be adjudicated with justice to both the individual concerned and the government. Of far more consequence than its potential informational value was the fact that the psychiatric evaluation might be utilized prophylactically and therapeutically as well. Some World War II repatriates developed a syndrome(16) characterized initially by excessive drinking, spending, or both. This was followed in turn by excessive demands upon family and environment. There was considerable difficulty in renewing old friendships or establishing new ones with a pathological dependence upon fellow former prisoners and

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

The views expressed in this paper are those of the author and do not necessarily reflect official opinion of the Department of the Army.

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a tendency on the part of the repatriates and physicians alike to explain their failure on the basis of "rice brain." This group subsequently proved incapable of adjusting to either civil or military life. We believed that the delineation of specific anticipated problems of adjustment to the repatriated prisoners of the Korean War at the time of their psychiatric evaluation might forestall the development of the above-described syndrome. The chief anticipated problems were:

1. *The Hero-For-a-Week Problem.*—It appeared evident that upon their return to America the repatriates would be regaled in a fashion generally reserved for national heroes. During this period of extreme permissiveness everything possible would be done for them; they would be wined, dined, and given gifts. Some men, failing to recognize that this was to be a limited period, might persist in making unreasonable demands of the environment on the grounds that they were indeed "heroes." For others, this period of adulation might serve to awaken repressed feelings of guilt over being captured. The inevitable eventual withdrawal of dependent gratifications would prove a disillusioning experience for all.

2. *The Problem of Communication.*—During periods of prolonged imprisonment a distinctive idiomatic communication system among groups of fellow prisoners is evolved. In such a system striking condensations, displacements, and references occur so that one not thoroughly familiar with the system has great difficulty at times to understand what the real meanings are. Hence, prisoners of war upon their return may find a strange lack of understanding between themselves and those who have not been prisoners. This could create a feeling of rejection, helplessness, and frustration in being unable to make satisfying human contacts. They might then find their greatest comfort for some time in meeting with old fellow prisoners of war who, alone among all others, would speak their language.

3. *Return to a Disinterested or Hostile Environment.*—Men who had spent up to 32 months in captivity might find it highly traumatic on their return to America to learn that the Korean War had been quite unpopular. Some unthinking individuals might even refer to them as "stupid" for having taken a part in this war.

4. *Curiosity Seekers.*—Individuals who approached and questioned repatriates about their experiences, not out of genuine interest, but rather through curiosity might well present a challenge to the former prisoner's ability to continue suppressing hostility.

OPERATION LITTLE SWITCH

In order to handle the expected heavy work load, additional psychiatrists augmented the staffs of the 2 hospitals designated to receive Little Switch returnees.

Following their return from enemy hands the men were taken by helicopter to an Army Evacuation Hospital near Seoul, Korea, where they received a brief physical examination. On the following day they were airlifted to Tokyo. The entire medical and psychiatric examination had to be completed within 3 days of their arrival in the Tokyo hospitals.

The findings of the comprehensive medical evaluation performed on 68 repatriates is reported elsewhere(17). Included in that report is a brief survey of the psychiatric findings. In general, all of the patients initially showed a marked disinterest in their environment. They appeared bland, apathetic, and retarded. Their affective display was carefully modulated. Talk was shallow, often vague, and with definite lack of content. Large memory gaps were present, particularly for the period of capture and the so-called "death marches." There was little if any spontaneous talk of home, family, or future. Such future plans as were mentioned were of a short-term nature, poorly conceived and highly unrealistic.

This initial picture was labelled the "zombie reaction." In most cases 3 days after release from imprisonment the blandness and apathy cleared spontaneously and was replaced by a mild euphoria. More interest was shown in personal appearance and cognizance was taken of the environment. The entire group demonstrated an incredible degree of cooperation with the medical authorities. Despite newspaper stories available to and read by the repatriates of the warm welcome awaiting them upon their return to America, there was no pressure on

their part to return home immediately. In fact, many requested that their return to the States be delayed in order that time might be gained for resolving present and anticipated anxieties.

In discussing the Communist indoctrination program, the men presented perseverative, stereotyped responses. There was considerable confusion expressed as to who really started the Korean War. The majority believed that our forces had actually used germ warfare although most of the men felt "it was all right for us to do that in a war." Many expressed antipathy toward the Chinese Communists, but at the same time praised them for the "fine job they have done in China." Others stated that, "although Communism won't work in America I think it's a good thing for Asia." There was considerable hatred of the North Koreans for the brutal treatment they had given. However, none of the prisoners expressed any deep-seated hatred towards the Chinese Communists. Contrariwise, most felt that the "Chinese treated us the best they could."

It was evident to the examining psychiatrists that although the majority of repatriates did not suffer from any specific psychiatric disease, they were nonetheless abnormal. They appeared "suspended in time," confused by their newly acquired status, and incapable of forming decisions regarding their future course of action. The pressure of concentrated medical, psychiatric, and administrative processing, coupled with newspaper accounts which told of mounting concern over the possibility of their having been successfully indoctrinated by the enemy, gave rise to mounting tension and anxiety with fears of nonacceptance by family and Army alike. At this point there was a clear and evident need for psychotherapeutic measures.

Because of the serious time and personnel limitations under which we were operating, the only feasible method was group psychotherapy. Three random groups of 6 to 10 repatriates were asked to participate in group therapy. At the first meeting of the group, the psychiatrist[3] explained that imprisonment often produces emotional problems and that a discussion might prove helpful in resolving some of them. The men did not respond to this relatively nondirective approach, appeared quite apprehensive and suspicious and, for the most part, remained silent. When the interview was structured by introducing specific problems of adjustment (hero for a day, communication, etc.), they were able to discuss these in a limited way.

One striking fact emerged: psychiatrists and repatriates alike recognized that an insufficient period had been allotted in which to prepare them for their return to the United States. At the time of their departure from the hospitals in Tokyo, the majority were tense, anxious, insecure, perturbed, and in considerable doubt as to their future status.

While it is questionable if much lessening of anxiety took place in the 3 group therapy sessions possible, it was believed, nonetheless, that with more time this approach might have yielded satisfactory results. Therefore, it was strongly recommended that group psychotherapy be carried out over an appreciable period with all of the men who were to be repatriated in Operation Big Switch.

OPERATION BIG SWITCH

Only the sick and wounded were to be returned to the United States through hospital channels. All others were to be maintained briefly in a replacement depot, especially prepared for them, at Inchon, Korea, and then to return to America as ambulant patients via ship. The voyage of approximately 14 days duration was to be utilized for necessary medical and administrative processing. The Department of the Army requirements for the medical evaluation remained unchanged. Since the psychiatric evaluation performed in Operation Little Switch proved of value, no change was made locally in our basic requirements. We did, however, stress the need for prophylaxis and therapy both in individual psychiatric interview and supplementary group psychotherapy. It was recommended that attention be

[3] Dr. David McK. Rioch, Director, Neuropsychiatric Research Division, Army Medical Service Graduate School, Washington, D. C., and Major F. Gentry Harris, MC, USA, Chief, Psychiatric Far East Research Unit, AMSGS, Washington, D. C.

focused on the "here-and-now" situation and that no efforts be made to give depth therapy. It was recognized that underlying guilt, once stirred up, could not easily be handled.

The author was assigned to Inchon during Operation Big Switch as Chief Psychiatrist and Liaison Officer for the psychiatric processing teams assigned to each transport carrying prisoners of war to America. From the psychiatric standpoint, Operation Big Switch was truly an example of unification. Army, Navy, and Air Force psychiatrists, psychologists, and neurologists from Korea, Japan, the Ryukyus, and the United States took part.

It was evident at the outset that in the limited time and with the available personnel a proper neuropsychiatric evaluation could not be performed aboard ship. More serious, there would be no opportunity whatsoever for the essential therapeutic mission. Accordingly, plans were made to perform as many psychiatric evaluations as possible while the repatriates were at Inchon awaiting ship. In addition to providing necessary time for therapy this plan enabled the psychiatric teams to become familiar with their duties prior to boarding ship. A total of 1,301 repatriates or approximately one-third the total number repatriated received their initial psychiatric interview at Inchon.

In contradistinction to the hospital environment of Operation Little Switch, which, though friendly, was firm and military, the environment at Inchon was one of permissiveness beyond description. The men were given virtually "everything," and this created no reality for them. They repeatedly attempted to test the limits. Many failed to keep appointments. A number went AWOL and returned drunk and disorderly, etc. It soon became apparent that limits had to be set. The establishment and maintenance of military discipline produced no dire consequences. The unrealistic and all-too-permissive attitude at Inchon did little to facilitate the sorely needed re-identification with the Army. The men remained, as in the prison camp, a noncohesive, nonintegrated group of isolates. Their behavior en route to America and an account of the effects of group psychotherapy is reported in an article by Lifton(18).

The majority of repatriates who had spent over 6 months in prison camps initially presented the picture of the "zombie reaction." They differed somewhat from those seen in Operation Little Switch since they were less bland and more interested in their environment. Although superficially cooperative, they were considerably more guarded during interview than the first group. Following Operation Little Switch the Communists repeatedly informed the remaining prisoners that they would be persecuted and prosecuted following their return to America, "since most of the men repatriated in Operation Little Switch had been declared insane and sent to Valley Forge Army Hospital."

The men continued to behave at Inchon as if still in Communist prison camp. Affect was very carefully controlled and there were few overt evidences of aggression or hostility (forbidden feelings in camp). Talk was shallow, vague, and with little content. Large memory gaps were evident, particularly for the period immediately following capture. There was little spontaneous talk of family or future. They banded together in small groups of 2 or 3 and appeared to be noncohesive and isolated. Their group identifications maintained prior to capture were apparently absent. The repatriates identified themselves as prisoners of war or former prisoners. They referred to "The Americans" or "American Forces." Many responded to the question, "What unit were you with?" with the reply, "Camp Number so-and-so."

As was predicted after Operation Little Switch, the repatriates exerted practically no pressure to return to America immediately. A sizeable number wanted to obtain leave in Japan. A review of prisoners evacuated to Japan ostensibly for medical reasons disclosed that a large number had no medical condition which necessitated evacuation. They had merely succeeded in fighting a delaying action with a sympathetic medical officer.

INDOCTRINATION

At one time or another every soldier engaged in combat considers the possibility of death or serious incapacitating injury. However, very few repatriates experienced fan-

tasies of possible capture and imprisonment prior to actual capture. When taken prisoner the overwhelming majority experienced for the first time fantasies of torture and death at enemy hands. This was certainly a realistic fear when the prison camps were under North Korean control. However, during the period the camps were administered by the Chinese Communists, it was quite apparent that the enemy was far more concerned with indoctrination than with death or physical torture. Yet, until the very closing day of the war, men when captured continued to feel that death and torture were inevitable.

The Chinese exploited this fear of the unknown. At the time of capture the enemy assured our soldiers by word and deed that they would be unharmed and well treated. This produced a state of emotional confusion since the captive felt gratitude toward his captor for having spared him from torture and death. From time to time the enemy utilized the fear of the unknown (death or torture) to induce compliance and cooperation. This was achieved through subtle hints at torture, occasional physical mistreatment, chiefly in the form of slapping or the maintenance of uncomfortable positions for long periods, solitary imprisonment, deficient diet, on rare occasions dummy firing squads and, perhaps worst of all, threats of removal to Siberia with eternal nonrepatriation.

The Communists employed every possible means of denying internal leadership to the prisoners. The absence of organized resistance and of escape, food, and intelligence committees within the camps is testimony to their effectiveness in destroying the group's internal controls. This was achieved first through segregating officers into a separate camp. The stabilizing influence of noncommissioned officers was similarly removed through their transfer to a separate camp. The majority of men were thus deprived of leadership, discipline, and group identification with subsequent loss of morale and poor esprit. As natural leaders emerged from within this group, they were removed silently and expeditiously to reactionary camps.

The prisoners were then divided into squads under the leadership of a Chinese Communist squad leader who, in addition to constant spying and informing upon the squad members, was also responsible for its discipline and indoctrination. A new group identity with entirely new basic codes, concepts, and behavior was to emerge. Its most striking feature was the fact that it was really a group of isolates.

The loss of personal and group identity was a first step in the path towards isolation. Prisoners were addressed by their last name only and told they had no rank since they were no longer soldiers but prisoners and war criminals instead. Regulation of mail from home provided the enemy with an insidious and ingenuous method of destroying the home ties. Letters which were pleasant or at least neutral in nature were deliberately withheld. Those of a complaining or pessimistic nature were delivered uncensored to the men. Because of the depressing effect of such letters, many ceased to look forward to mail from home and tended to lose their identification with the family.

The autobiography required of each prisoner became an effective enemy tool for proving the presence of at least one "enemy of the people" in each man's family. In the Communist's scheme of things there were no longer crimes against the individual, only crimes against the people. Hence, the theft of a single turnip became a crime against the poor people of North Korea and the thief a war criminal whose punishment could be exile to Siberia.

Isolation was further fostered through the use of confession and self-criticism. Although the latter technique (whereby one criticises one's own shortcomings before the entire group) was more applicable to Orientals with their strong need for "saving face," it was nonetheless quite effective with our prisoners since the criticisms were recorded and filed and one never knew when enough "evidence" had been amassed to cause his exile to Siberia. Confession was mandatory. Not to confess, even though the confession implicated family, friend, or country, became a crime against the people. Under such circumstances the "buddy" system described in World War II POW societies was not possible for no one could trust even himself not to inform upon himself. Having confessed once, the prisoner must perforce confess al-

ways, lest he be accused of not telling the "truth" and hence a war criminal. There was no compromise with the "system," having entered there was no turning back.

Each squad of prisoners received relentless daily propaganda instruction under the supervision of the Communist squad leader and an "elected" monitor. In an appeal to open-mindedness and American fair play, men were enjoined to "just listen to our side of the story." The material presented was not ludicrous so as to cause ridicule nor was it venomous to arouse group hostility. Instead, it concentrated on such topics as "the maldistribution of wealth in America," "racial and class discrimination," and "America's imperialistic designs in starting the Korean War and threatening the borders of peace-loving Red China." The Communists presented themselves as "being interested in the people and in peace," a subject dear to the heart of every soldier, particularly one in an enemy prison camp awaiting repatriation. The principal ego support given the group was an opportunity to work for peace (certainly an acceptable gratification). Besides, not to work for peace was to be an enemy of the people—and hence unfit to live! In addition to the supposed privilege of working for peace and for the people, the Communists also rewarded cooperative individuals with extra creature comforts in the form of extra privileges, food, cigarettes, etc.

Those prisoners who, for any reason, took an active part in the enemy's indoctrination program were used by the enemy to "sell" others on the need to take part. Many men have rationalized their cooperative behavior in prison camp as being due to the fact that "an American Officer told me it was all right to do that."

EFFECTIVENESS OF THE INDOCTRINATION PROGRAM

Measured in terms of conversion to Communism, the enemy's program was quite ineffective since relatively few of our prisoners were actually "converted to Communism"(19). Nor does it appear too likely that this was the enemy's prime intent. Measured in terms of confusion, unceasing anxiety, fear, needless death, defection, disloyalty, changed attitudes and beliefs, poor discipline, poor morale, poor *esprit*, and doubts as to America's role, their efforts were highly successful.

SUMMARY

1. The planning, modus operandi, and initial psychiatric findings and impressions of Operations Little Switch and Big Switch are discussed.

2. Reference is made to the Communist Indoctrination Program (brain washing); its methods and effectiveness are discussed.

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PSYCHIATRIC CONSULTATIONS[1]

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It is the purpose of this presentation to offer suggestions for the more adequate care of the patients with whom referring physicians and psychiatrists are mutually concerned in psychiatric consultations. These situations offer excellent opportunities for improving the relations between medicine and psychiatry, and their more intelligent management would be in keeping with present-day scientific knowledge. In many instances psychiatric consultants function as though they have no understanding of psychodynamics, and they appear to imitate the referring physicians whose orientation is in organic medicine. For example, they comply with requests for their opinion and advice, and report their findings and recommendations to the physicians whose patients they have examined. How often this standard procedure, which a descriptive psychiatry adopted from the practice of medicine, is helpful to other physicians and their patients is not known, but it is not in accord with the knowledge that has been acquired regarding interpersonal relations. It is known, however, that in many instances psychiatric consultations have been of far less assistance to other physicians than they might have been and that too often they have aroused justifiable feelings of distrust and dislike for psychiatry in competent medical and surgical clinicians. These observations focus attention on the problems peculiar to psychiatric consultations and the attitude of psychiatrists toward referring physicians.

This paper is concerned with those situations in which physicians request the psychiatrist's opinions and recommendations regarding patients who have been in their care for some time, and also those in which physicians wish to recommend patients to psychiatrists for treatment. In either case the psychiatrist has the responsibility of conferring with the physician before deciding to see the patient in consultation or to accept him for treatment. These conferences afford an opportunity to learn the patient's history and family situation; the onset and history of the present illness; the facts about the therapy; and the all-important information regarding the doctor-patient relationship.

The indication for these conferences is dictated by the following facts: The psychiatric consultant, unlike any other medical specialist, needs to have concern not only for the patient to be referred but also for the physician who wishes to refer him. This concern is centered upon the necessity for learning what one can about their relationship with each other and whether it is advisable to intervene by seeing the patient in consultation or to disrupt the relationship by taking the patient into treatment. Everyone would agree that it is an injustice to both the referring physician and his patient to interfere solely to relieve the physician of his anxiety over transference or his frustration in not being able to do more for his patient. Both these reasons account for many of the requests for psychiatric consultations. In such instances would it not be more desirable to encourage a colleague to continue his care of the patient and do everything possible to allay his anxiety and assist him in lessening his personal dissatisfaction? In conversing with other physicians about their patients, and especially as to how they feel about them, it is often somewhat of a surprise to discover that they secretly wish to continue the care of the patients they refer for consultation if only they might have the benefit of occasional supervisory assistance. As a rule, the psychiatrist needs to take the initiative and he is in good position to do so if he has sufficient time and interest to listen to his medical colleague in need of his help. Psychiatrists regularly criticize other medical men for not allowing their patients to talk about their personal and social problems, but they in turn tend to behave in a similar fashion toward their medical colleagues when they request consultations. They often overlook the necessity of imagining themselves in the place of the other physician, who may be timid, em-

[1] Read in the Section on Private Practice at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

barrassed, or otherwise disinclined to discuss what he really needs and wishes to discuss with the psychiatrist. Every practitioner of medicine is more or less emotionally involved with his patient. He may be consciously aware of how he has inadvertently contributed to make his treatment of his patient more difficult. He may even be aware of his irrational fears or his untoward feelings, but he cannot speak about these problems unless he senses a friendly and understanding attitude and a wish on the part of the psychiatrist to take time with him. The psychiatric consultant must regard many a medical confrere as if he were an intelligent layman because he has not had the benefit of any training in psychiatry and must depend entirely upon his intuition. A greater respect for him as one who practices medicine with much the same handicaps as every psychiatrist in his early experiences with patients would go far toward making friends for psychiatry and for better patient care.

It would be well for practicing psychiatrists to attempt to orient the members of their local medical societies regarding the problems peculiar to psychiatric consultations. It would be well, for example, to explain the wisdom of conferring personally with psychiatrists whenever they intend to request psychiatric consultations and to do so prior to discussing this intention with patients to be referred. It should be emphasized that psychiatrists are interested and willing to assist other physicians with problems involving the care of their patients; that personal consultations can be of value in having patients remain in their care. Psychiatrists need to acquaint other doctors with the role of transference in medical and surgical therapy; the emotional trauma which many a patient experiences in being transferred out of their care; and that frequently they are doing more for their patients than they realize. There is an urgent need for psychiatrists to orient other members of the profession regarding the methods they might employ in speaking to their patients about the need for consultation with psychiatrists; how important it is for their patients that they not make promises to them; not to speak of referring them for psychoanalysis; how to help them understand the function of psychiatrists in the practice of medicine; and how they might prepare them for such consultations. It is important that prior to any discussions with their patients they make certain that psychiatrists can arrange for appointments and can accept patients into treatment if necessary.

These are but a few of the many facts peculiar to psychiatric consultations. If members of local medical societies are acquainted with them they may thereby be able to render more satisfactory professional service and the contributions of psychiatry may become of practical assistance. This and this only is what the term "consultation" signifies.

DISCUSSION

Zigmond Lebensohn, M. D., Washington, D. C.—Dr. Bartemeier empasizes the need to give more consideration to the referring physician in order to learn from him directly all one can about his patient, the patient's family, and to explore the possible motivations for the consultation. This is the procedure every psychiatric clinician uses when, in addition to what he learns from the patient, he interviews a member of the patient's family. The referring physician's role is somewhat similar to that of the patient's relative. When psychiatrists give proper consideration to the referring physician and his knowledge of the patient who has been in his care for several years, they not only manifest the respect due their professional colleagues but pursue a course of investigation characteristic of every serious clinician.

Referring physicians are often justified in their complaints that they have been disregarded by psychiatric consultants; that they have been treated as if they knew nothing; as if they were unimportant figures in the situation. These complaints can no longer be disregarded if psychiatry and medicine are to share their knowledge more closely.

Nothing has been mentioned so far about the psychiatrist's recommendations and evaluation of his findings. Here, again, it is more satisfactory to meet and discuss this information personally with the referring physician. He may also wish a written report for his records, but this can never equal the value of a personal visit. For the average physician a psychiatric consultation is a serious matter, and no psychiatrist can afford to regard it in any other light. Finally, in order to obtain an evaluation of one's consultive services, there is opportunity to learn from the physician his patient's reaction to his visit with the psychiatrist. In every instance the effort must be primarily in the direction of the referring doctor—to consult with him in every sense of the word.

A STUDY OF JUVENILE SEX OFFENDERS[1]

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A voluminous literature is available on problems presented by adult sexual offenders. This literature is related to the clinical findings, diagnosis, and suggested treatments, and to various legislative proposals designed to control the problem. In contrast, there is very little clinical or statistical material available on the juvenile sex offender as seen in juvenile courts. Kanner(1) points out that most of the available case material, from which studies of juvenile sex behavior can be made, comes from the juvenile courts. There is some evidence that the child offender is often the precursor of the adult offender(2). This underlines the importance of studying this problem and attempting to analyse it in the juvenile area.

The purpose of the present study is to offer some basic statistical definition of the problem as observed in Toronto over a period of years. The Toronto Juvenile and Family Court has had a full-time psychiatric clinic since 1920, and fairly complete records have been maintained. It is from this recorded clinical material that we have chosen a representative group of cases from which to assess the incidence and pattern of juvenile sex delinquency. In the jurisdiction of this court a juvenile is described as a child below the age of 16 and over the age of 7. Our description is therefore taken from a group of children and young adolescents whose sexual behavior is sufficiently disturbing to the society in which they live that they are charged before the court as delinquents. The clinical records used for this survey do not permit a thorough investigation of the psychogenic factors involved nor do they allow for an accurate assessment of treatment or follow-up. The records are, however, sufficiently detailed to allow for preliminary analysis and classification. The court's concern about offences against sex mores is such that it almost invariably refers cases involving sexual misbehavior for clinical investigation. A previous study established that 90% of all sex offenders appearing before the Toronto Juvenile Court are referred for clinical study compared with 55% of all offenders so appearing. It is our conclusion, therefore, that material referred to the clinic represents a true cross-section of the total sex offender problem coming before the court.

Accordingly, a statistical survey of all sex offenders appearing in the clinic between the years 1939 and 1948 was conducted. The findings were compared with a randomly selected sample of other offenders. In this 10-year period 3,112 juvenile delinquents were referred to the clinic, 2,516 male and 596 female. Of these, 5.8% of the boys and 34.5% of the girls were involved in sexual misbehavior. Kanner states that in 88 juvenile courts in the United States in the year 1930, 2% of the boys and 21% of the girls were arraigned because of sex offences. While our data show a similar male to female ratio, the absolute incidence is higher in both cases because we have included not only children charged with sex offences but also those who, regardless of the charge, were discovered on clinical examination to be sexually promiscuous or to be demonstrating unusual sex behavior. Because of the higher incidence of sexual misconduct among the girls, as compared with the boys, we have conducted our comparative analysis of these cases in terms of 2 parallel studies, one for each sex. It follows that the data cannot be interpreted for juvenile delinquents in general since the particular control groups were randomly selected to approximate the absolute numbers of male and female sex offenders separately. The 10 years studied yielded a total of 283 sex offenders, 116 boys and 167 girls. The number of these offenders varied from a low of 19 in 1939 to a high of 39 in 1944. The control group was randomly selected within each year, so that the number of non-sex

[1] Read in the Section on Legal Aspects of Psychiatry at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

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offenders, male and female, approximated closely the number of sex offenders of that year. This procedure yielded a total of 294 non-sex offenders, 126 male and 168 female. A comparative analysis of these groups was then conducted in terms of (1) nature of the charge; (2) age; (3) I.Q.; (4) socio-economic stress; (5) recidivism; (6) committal to training school; (7) incidence of serious personality maiadjustment. The present study reports these findings and suggests an interpretation of them.

Sex offenders: Nature of Charge.—On assessing the cases of sex offenders, it became apparent that the charges could readily be classified in 3 categories: (1) Specific sex offences—exhibitionism, indecent assault, immorality, rape, indecent acts, etc. (2) Non-specific charges—vagrancy and incorrigibility, the charge being laid chiefly because of sexual promiscuity. (3) Unrelated charges—truancy, theft, breaking and entering, malicious damage, etc., in which sexual misconduct was also a presenting problem.

In utilizing these categories for classification of our material, 7.2% of the female sex offenders, as compared with 68.9% of the male, could be placed in the category of specific sex offences. This shows that in over two-thirds of the male experimental group the charge itself specifies a particular type of sexual behavior.

Of the female sex offenders, 79%, as compared with 18.9% of the males were classified in the category of nonspecific charges. It was also noted that of the 22 males so classified, 9 were involved in homosexual behavior with adults.

Thirteen per cent of the female and 12% of the male experimental group were brought to court under "unrelated charges."

It is apparent from these findings that specific charges usually involved sexual deviations in the male, whereas nonspecific charges are usually blanket terms implying promiscuity in the female and frequently sexual curiosity of a rather normal nature in the male.

Distribution by Age Interval.—Age distribution in the control group demonstrates 62.9% of the males and 87.5% of the females were between the ages of 13 and 16 inclusive. The remainder were between 7 and 12. This confirms the general findings in our total juvenile court population that boys tend to appear in court at an earlier age than girls.

In the experimental group, 79% of the males and 95.1% of the females were between the ages of 13 and 16, indicating that those considered as sex offenders are, on the whole, older than the general juvenile court population in the case of both the male and the female.

I.Q. Distribution.—Approximately 90% of I.Q. scores were derived from the Stanford-Binet Scale, the remainder from group tests distributed randomly over the 10-year period.

The average I.Q. of the male experimental group was 91.9, as compared with 94.5 in the control group. In the female experimental group an average I.Q. of 92.2 was obtained, as compared with 92.6 in the controls. It would appear, therefore, that there is no significant difference in the average I.Q.'s of the sex offenders and the control group. With the males, however, there is a somewhat greater spread or variability of scores, as indicated by a higher standard deviation. The standard deviation in the case of the male sex offenders was 17.7, compared with 14.9 in the male control group; whereas, in the female experimental group, it was 15.6 compared with 16.37 in the controls. This greater spread emphasized the advisability of determining the incidence of defectiveness. For this purpose a defective was defined as a child with an I.Q. below 80, regardless of the clinical impression of his adequacy of functioning. Using this definition, there were over twice as many defectives among the male sex offenders as among the controls, the percentage being 25.2% of the male experimental group, as compared with 11.1% of the male controls. There was, however, no significant difference between the female experimental group, in which 19.5% were below I.Q. 80, and the female control group, in which 20% were below this figure.

Socio-economic Stress.—In a previous (unpublished) study, it was shown that independent judges could reliably detect in a history evidence of "less than marginal income," "unsatisfactory home," and "broken home." These categories were defined as follows: (1) Less than marginal income—

If the family has, at any time during infancy or childhood of the delinquent, been dependent on the municipality or a social agency for financial aid, or if the mother has had to supplement the family income, the income is considered less than marginal. (2) Unsatisfactory Home—This applies to the general home atmosphere and includes such factors as the sanitation, discipline of the children, parents' relationships to each other, presence of poor habits of mental hygiene such as alcoholism, etc., and also refers to the psychological relationships between family members. If any or all of these are judged unsatisfactory, this item is so checked. (3) Broken Home—This is checked if there has been a prolonged absence of either parent from the home or if the child has been placed in another home for any period. If the break is caused by death of either parent, then "death" also is checked; if by divorce, separation or desertion, then "separation" also is checked. Other absences such as military service, illness requiring long hospitalization (t.b. etc.), penitentiary sentences, are indicated by checking "broken home" only.

Using "less than marginal income" as an index of economic stress and "unsatisfactory homes" and "broken homes" as an index of social stress, there was no significant difference between the experimental and the control groups in the incidence of these factors either alone or in combination.

Recidivism.—Analysis in the case of recidivism was confined to males only. This was necessary because of the frequency with which charges indicating promiscuity in the female brought about committal of those children to a training school on their first offence. This indicates that both court and clinic are concerned over the risk of pregnancy and venereal disease in the female. The need of a controlled environment in the case of the female offender for her own protection is obvious. For these reasons, no analysis of female recidivism was undertaken.

For our purposes recidivism was defined as one or more reappearances in court on any type or number of charges. In order to deal with the wide variety of charges laid, a previous study of juvenile offenders was used in which the following categories were listed: (1) Stealing—defined as including all charges of unlawfully taking another's property: theft, armed robbery, breaking in, etc. (2) Nuisance—defined as covering acts of mischief, disorder, and other irritations to the public peace: disturbing the peace, malicious damage, etc. (3) Sex—covers all charges involving a breach of the sex mores: includes all subjects in the present experimental group. (4) Behavior disorders—covers all cases in which the nature of the offence suggested emotional disturbance, a failure to adjust to social standards: truancy, running away, etc. (5) Miscellaneous—includes a few unusual offences not readily classified: offences against the Liquor Control Act, etc. The charges laid against male recidivists in both the experimental and control groups, were classified under these categories in order to compare (1) the total incidence of recidivism in each group; and (2) the degree to which recidivism exhibited any consistency of pattern, *i.e.*, does a recidivist continue to steal or is he likely to reappear for an entirely different offence and, by the same token, does the sex offender continue his sexual offences?

Analysis of our control and experimental groups indicates that there is considerably less probability of recidivism of any type among sex offenders in comparison with the control group; 40.5% of the experimental group are recidivists compared with 54.7% of the controls. Repetition of sex offences occurred in only 3 cases or in 2.6%; while 97% did not repeat their sex offences, at least while still in the juvenile age group. An analysis was carried out to determine the degree to which recidivists in the experimental and control groups repeated the same category of charge. Of the sex offender recidivists, 47% were consistent by category and 53% inconsistent. The non-sex offender recidivists were 78% consistent by category and 22% inconsistent. There is then no consistent pattern of recidivism for sex offenders, but there is a fairly high probability that the control group cases will repeat in the same category of offence.

Committal to Training School.—Our analysis demonstrated no significant difference in the percentage of males committed in

the experimental (20.6%) and the control (18.2%) groups. There was, however, almost double (47.3%) the percentage of females committed in the experimental as in the control group (25.5%). On first examination it would appear from these data that the court discriminates heavily against the female juvenile sex offender, even though the offence that brings her to court is seldom, if ever, the bizarre sex behavior characteristic of the male offender. Such an interpretation is, in our opinion, totally at variance with the facts. Because of the obvious danger to the child concerned (pregnancy, abortion, venereal disease, etc.), both court and clinic, as agents of society, use the training school as a treatment device to protect the girl from these hazards. At the same time, the court refuses to be stampeded by public outcry into wholesale and essentially vindictive committals in the case of male juvenile sex offenders, since experience dictates that this would serve no useful purpose.

Incidence of Serious Personality Maladjustment.—Personality maladjustment, for the purpose of this study, has meant major personality disorder as indicated by (1) direct mention of abnormal mechanisms in the recorded psychiatric examination; (2) a record of remand to a psychiatric hospital for examination; (3) committal to a psychiatric hospital; (4) direct referral to a psychiatric clinic. Any one or more of these factors was used as an index of serious mental or personality disorder. It was assumed that the probability of these indices being recorded if present was equal for both control and experimental groups.

Our findings indicate that among the male group of sex offenders the incidence of psychiatric disorder is 6 times as great as in the control group (20% versus 3.2%). There is no significant difference between the female groups in this regard (11.3% versus 14.8%).

Conclusions and Interpretations

1. *Incidence.*—In the juvenile delinquent population there are far more girls than boys brought before the court for sexual misbehavior.

2. *Age.*—Compared with a control group, sex offenders are on the whole older than non-sex offenders.

3. *Intelligence.*—There is no significant difference between the average I.Q.'s of sex offenders and non-sex offenders. Among male sex offenders there are twice as many defectives as among the controls, whereas, there is no such difference between the female groups.

4. *Recidivism.*—There is a lower recidivist rate (regardless of charge) for male sex offenders compared with the control group. There is no predictable consistency revealed in the type of charge among the sex offenders, while there is a fair degree of consistency among the non-sex offenders. It is extremely unlikely that the male juvenile sex offender will reappear on a second sex charge, at least up to the age of 16. This finding might lead to the erroneous conclusion that these problems are easily controlled and do not present a serious indication of emotional disorder. The complete study, however, indicates a need for a closer follow-up of these cases.

5. With the foregoing as a background, 3 further findings stood out as being interrelated and of particular importance: (a) the nature of the charge which clearly differentiates between male and female offenders in terms of the way they are dealt with in court; (b) the disposal of the charge which again differentiates between the male and female in terms of the way they are dealt with in court; (c) the incidence of serious personality maladjustment which clearly differentiates sex offenders from non-sex offenders.

Using these 3 findings as a basis, we have constructed a tentative classification and interpretation of juvenile sex offenders as outlined below.

1. Emotionally disordered sex offenders whose sex behavior is a symptom of profound personality maladjustment: our findings would indicate that these are most frequently males, and we feel it reasonable to hypothesize that many of this group continue to create a problem in adult life or to demonstrate more serious mental disorder although they are not recidivists as juveniles.

2. Defective sex offenders: Male defectives are somewhat more prone than females

to be involved in sexual activity that will bring them before a court.

3. (a) Normal heterosexual female delinquents: These girls are promiscuous in an attempt to gain status, affection, and security. (b) Normal heterosexual male delinquents: These acts appear to be based on a developing sex curiosity.

While we readily agree that each case must be dealt with as an individual problem from a psychotherapeutic viewpoint, our classification indicates the general areas within which such individual treatment will be conducted. Furthermore, this classification points out the need for certain community resources, such as special casework, to handle the problem of the normal male whose act is based on developing curiosity or in certain cases of female promiscuity where secure family relationships appear to exist. Training schools are more frequently needed for the promiscuous female for her own protection. Since certain male defectives studied are prone to commit indecent acts and since they possess little potential for growth in social judgment, special training schools for defective male delinquents are obviously needed. It is a matter of general experience that male defectives adjust poorly in training schools where they are grouped with male juveniles of normal to superior intelligence. Again, because of their backgrounds and patterns of behavior, they often become difficult problems in hospitals for the training of nondelinquent, mentally defective children.

The relatively large percentage, especially in the male, of serious personality disorders among the juvenile sex offender group, is a definite indication of the need for inpatient diagnostic and treatment centers for children. The psychodynamics of these cases seem rarely to be worked out by the usual child guidance methods. The eventual understanding of the etiology and psychopathology of abnormal sexual behavior in the adult must come from an intensive and systematic study of the emotionally disordered, sex delinquent child.

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MORAL TREATMENT AND THE MENTAL HOSPITAL[1]

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This paper proposes to review briefly the trends in hospital care of mental patients and to consider whether successful experiences of the past might be adapted and profitably applied today in the light of our current psychiatric theory and practice.[3]

SOCIAL VALUES OF THE PAST

The history of the mentally ill parallels the history of civilization. Where there existed an enlightened society, the mentally sick were treated with tolerance and understanding. When social eras were dark, the intolerance and bigotry of the times were likely to be expressed particularly toward the insane. The attitudes of society influence greatly the worth of the individual and, in turn, the role of the individual in society is determined by the attitudes and cultural values of society.

The great Revolution in France at the close of the eighteenth century, with its *Liberté, Egalité, et Fraternité,* forecast a new era in social values. For the mentally sick, wandering through the countryside, hidden in almshouses or chained in prisons, a new era, too, was born as Pinel struck the chains from the insane at the Bicêtre.

As the nineteenth century dawned, the demonological causation of mental illness was no longer believed, but in general etiology was as obscure then as today. Benjamin Rush(1) believed that

> the cause of madness is seated primarily in the blood vessels of the brain and that it depends upon the same kind of morbid and irregular actions that constitute other arterial diseases.

At any rate, the treatment included elaborate formularies with exotic ingredients and such remedies as bloodletting, purging, the use of emetics, blistering, warm and cold baths, and the pouring of cold water down the sleeves of the afflicted one. Dr. Rush also invented several ingenious machines known as the tranquillizer and the gyrator which reduced the activity of the violent patient by making him dizzy. The management of the insane was often inhuman and callous since it was generally believed that the insane had no sensibilities. Consequently, they were kept in cold and in dirt, inadequately fed and clothed.

True, there had been some attempts to treat the insane humanely. In Italy, Vincezo Chiarugi (1759-1820) published his *One Hundred Observations on the Mentally Ill* and demanded the humanization of treatment. Anton Müller (1755-1827) in Germany had advocated more humane treatment. Jean Colombier(2) (1736-1789) in France observed, "It is to the weakest and most unfortunate that society owes most diligent protection and care." Slowly the times were changing but it took the drama of a Pinel and the quiet steadfastness of the Quaker Tukes in England to bring to the mentally sick a new form of treatment that came to dominate psychiatric thought and practice through the nineteenth century. It was called Moral Treatment.

MORAL TREATMENT

Moral treatment was based ". . . on the conception that mentally ill persons were by no means deprived entirely of susceptibility to the same influences that determine the behavior of well persons"(3). As a method of management for the mentally ill it became the basis upon which the new mental hospitals were organized. Moral treatment sought, by providing a hospital atmosphere which combined kindness, firmness, and individual attention, to help the patient to minister to himself. Occupational, recreational, and social measures of treatment were established. In this environment, with its well-regulated pattern for living, the patient was helped to resist his morbid impulses.

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

[2] From the Veterans Administration Central Office, Washington, D. C.

[3] This is an appropriate place to pay tribute to Dr. William Russell, Dr. Gregory Zilboorg, and Mr. Albert Deutsch, among others, who have made available to us the records of the past.

In 1816, Samuel Tuke(4), grandson of William Tuke, who founded the York Retreat in 1792, described the practice of moral treatment at that institution and summarized its objectives under 3 headings: (1) By what means the power of the patient to control the disorder is strengthened and assisted; (2) What modes of coercion are employed when restraint is absolutely necessary; (3) By what means the general comfort of the insane is promoted.

At its inception, moral treatment was differentiated from medical treatment and was usually the responsibility of the lay officials in the hospital. Perhaps the fact that several generations of Tukes were laymen contributed to this practice. But Pinel had also recognized this dichotomy. He had observed at the Bicêtre that the kindly, tactful, yet just and firm management of the patients by a remarkably able lay superintendent and his staff of disciplined attendants was apparently accomplishing more for their relief and cure than he was capable of with all his learning and resources as a physician. It seemed to him that he was witnessing a new form of treatment(5).

In America, the Pennsylvania Hospital, founded in 1752, had opened a department for the care of the insane. Exposed as it was to Quaker influence, moral treatment had been instituted. At the New York Hospital, too (opened in 1791), a ward for mental patients had been provided in the basement. Eventually, it became necessary to establish a separate department (Bloomingdale). The annual report for 1820 by the Governors of the hospital stated that the primary purpose of establishing an asylum was to provide moral treatment. The object was

> . . . to remedy a disorder having its seat in the mind, inhuman severity and unnecessary restraint have been usually employed. . . . a new method has at length been devised and an experiment first tried at the Retreat near York in England has demonstrated its superior efficacy. This consists of substituting mildness for severity, in affording the patient salutary employment and innocent recreation and in using appropriate means to banish gloomy and perverted ideas from the mind, to break morbid associations, and to restore to the patient that command over his own thoughts and imaginations the want of which is often the immediate cause of insanity(6).

At the New York Hospital, as late as 1825, moral treatment was the responsibility of the lay superintendent. In 1831, however, the Asylum Committee determined(7)

> The physician alone is responsible for the cure of patients and the grand means of effecting this object is moral treatment; it therefore of right belongs to him.

Moral treatment had also been introduced at Hartford Retreat, founded in 1822, and at the McLean Hospital established in 1818 as the psychiatric branch of the Massachusetts General Hospital.

ASYLUMS

While moral treatment reached its zenith in the private mental hospitals, the state institutions had also introduced these methods in varying degrees. Williamsburg, founded in 1773, was visited by physicians but was administered by laymen until 1841 when Dr. John Galt assumed the offices of both keeper and physician. Kentucky established a mental hospital in 1824, South Carolina in 1828, and Ohio in 1835. Worcester State Hospital in Massachusetts opened its doors in 1833 and 1836 saw the first state hospital in New York at Utica. About this time, the "Gentle Warrior," Dorothea Lynde Dix, the New England maiden lady, was starting her indomitable campaign to improve the care of the insane. Her efforts, which led to the establishment of at least 30 mental hospitals, provided a pattern of psychiatric care that rendered a most useful service for many years and still endures in some places.

It may be recalled that the first state institutions for the mentally ill were small. Patients remained only for a limited time. If they did not improve or recover, they were returned to their homes or to county almshouses, or to whatever facilities were provided by family or community. The state institutions enjoyed admirable reputations. So great was the renown of moral treatment that a period of residence in the hospital atmosphere was considered sufficient to produce recovery. But while the state hospitals were serving an excellent purpose, they were not meeting the needs of the sick, especially the chronic insane whose plight was still

pitiful. Public pressures gradually forced the entrance of more patients into the state hospitals and their retention therein indefinitely. New institutions were erected as the older ones overflowed. In 1866 the new 1,500-bed Willard State Hospital in New York was opened solely for chronic patients but public opinion did not favor this type of hospital and the attempt was abandoned. But it proved a point. Earlier there had been violent debate among the members of the Association of Medical Superintendents (founded in 1844 and later to become The American Psychiatric Association) as to the suitable size of a mental hospital. There had been considerable opposition to large hospitals. Willard State Hospital showed that large hospitals were practicable.

At their inception, what are now the state mental hospitals had been called asylums, a name which was to remain for almost a century. They were places of retreat, of refuge, for the insane. But gradually the asylums which had started so brightly with moral treatment as their foundation of hope were to become places "of inhumanity and neglect"(8) and of "scenes that rivaled the horrors of Nazi concentration camps . . . hundreds of naked mental patients herded into huge barn-like, filth-infested wards, in all degrees of deterioration, untended, and untreated, stripped of every vestige of human decency"(9). As long ago as 1880, public indignation had been stirred by the treatment of the mentally ill in asylums and the National Association for Protection of the Insane and Prevention of Insanity had been organized.[4]

The transition from treatment hospital to custodial institution within the span of a century is an important sociological phenomenon. A discussion of the historical and social reasons for this change are beyond the scope of this paper. Part of the answer lies in the changes in social and political interests and philosophies wrought by cultural evolution. During the last quarter of the nineteenth century, standards of care in the asylums began to decline, aggravated by mounting admission rates to hospitals too small or too understaffed or too poor financially to care properly for their patients.

The increasing costs of operating the growing institutions made it mandatory that the state assume the financial burden. Toward the end of the nineteenth century, too, there had been an awakening of public interest in the welfare of dependent individuals, children, aged people, and the sick. Increasingly the state assumed more responsibility for their care and the level of care was directly proportional to the public interest and the public funds that were made available for such purposes. The isolation of the asylum, excluding the public as it did by its high fences and its attitude of hiding its sick, as well as the separation of psychiatry from the mainstream of medicine, was not conducive to stirring public interest except for occasional outbursts of indignation aroused by publicized incidents of maltreatment.

Another factor that may have contributed to the change in the mental hospitals was the collapse of what has been termed the cult of curability. Success of moral treatment had spurred on its popular acceptance. In 1827, Hartford Retreat reported 23 admissions and 21 cures, a recovery rate of 91%. In 1850, Dr. Woodward, the superintendent of Worcester State Hospital, stated that the incidence of cure at his hospital was 90% (10). The competition between hospitals to report successful treatment grew keen. But eventually, scientific objectivity returned. Dr. Pliny Earle at the Hartford Retreat later reported that recovery rates for recent cases were 70% and about 20% for older cases. However, there were relapses, and the final recovery rate was only 34%(11). Dr. Earle made a plea for improved statistical methods.

As the Association for Medical Superintendents spearheaded the drive for more accurate statistics, the recovery rates decreased sharply from the earlier reports. The swelling ranks of the chronic insane confirmed the new findings and may have engendered the feelings of apathy and even hopelessness among the public, the hospital staffs,

[4] This organization comprised mainly neurologists and social-minded citizens and existed only a few years. Its purpose was to abolish restraint, provide stricter safeguards against illegal commitment, encourage more "liberty" for patients, control despotism of the superintendent, create central lunacy boards, and provide more research in mental institutions(9).

the relatives of patients, and even among the patients themselves. So did custodial care replace active treatment. It provided shelter, food, and clothing, kept the buildings and the patients reasonably clean, and at a minimum of expense. Amazingly enough, many patients did recover enough to leave the hospital but too many remained, giving credence to the concept of the deteriorating effects of mental illness. Deterioration and incurability were linked together. And so the circle was closed. Of what use to spend money and effort on incurable cases?

THE SCIENTIFIC ERA

The German and French schools of neuropathologists were making remarkable studies as the nineteenth century drew to a close. Of particular interest were the numerous degenerative diseases of the nervous system which had been identified as clinical entities. Into this scientific atmosphere, Kraepelin presented his epoch-making psychiatric nosology. It will be recalled that he divided psychoses into 2 major groups, those which resulted in recovery and those which went on to secondary forms (as deterioration or dementia). The gloomy prognosis for mental patients who showed evidence of so-called deterioration did not contribute to their treatment; if anything, it reinforced their abandonment to custodial care. Nor did Freud's new theories, which burst upon the psychiatric scene during this time, offer much to psychotic patients, for Freud did not believe they were amenable to treatment by his new method of psychoanalysis.

In 1911 Bleuler published his classic monograph on schizophrenia and, on the basis of clinical experiences at Burghölzli, took issue with the view that apparently deteriorated schizophrenic patients had a poor prognosis. Bleuler declared that improvement even in chronic states was always theoretically possible(12).

Bleuler's comments on the mental hospital are pertinent to our discussion.

> The institution as such does not cure the disease. However, it may be valuable from an educational viewpoint, it may alleviate acute, agitated states due to psychic influences. At the same time it carries with it the danger that the patient may become too estranged from normal life and also that the relatives get accustomed to the idea of the institution. In general, it is preferable to treat these patients under their usual conditions and within their usual surroundings. . . . The institution will attempt to educate the patient to act in a more acceptable manner. . . . The only and often practical criterion for hospital release is the patient's capacity to react in a positive manner to changes in environment and treatment. . . . The general task of treatment then consists in educating the patient in reestablishing his contact with reality.

The aim of the patient's education is the development of self-control and that patients should be helped to become accustomed to freedom. Most important of all is Bleuler's (13) statement:

> The principal rule is that no patient must ever be given up.

Surely Bleuler, speaking with authority and the weight of experience, offered new hope to hospitalized mental patients and new ideas to those who administered the hospitals. And he indicated clearly the effect of the hospital upon the patient. Some of Bleuler's ideas met acceptance and were put into practice. Occupational therapy and attendant training were being introduced into most hospitals, reception services had been established, social work services were being born. And the newly born National Mental Health Association, founded in 1909 by Clifford Beers as a result of his own hospital experience, was slowly beginning to move into action.

MODERN TIMES

The twentieth century has been a period of extremely rapid advance and change in this country in many ways. But the public mental institutions have not shared in the speed and until the end of the second World War were custodial institutions. Still, there had been growing awareness of human needs in relation to their social setting. Adolf Meyer, with his psychobiological approach, had opened new vistas and William A. White had pointed out the need for suitable conditions and adequate social research for each individual patient as part of treatment(14).

As our knowledge has grown, we have become aware of the contributions of sociology and anthropology to our understanding of mental disorder. We have come to see that mental illness arises in a matrix of social factors. Jurgen Ruesch writes that mental

disorders are in themselves a function of the culture in which they occur. Any person who does not fit into accepted conventions is declared out of bounds and relegated to a social institution where attempts at rehabilitation should be designed to facilitate participation in the type of human relations that predominate in a particular culture. Ruesch points out that we can understand a patient's human relations only against the background of his social situation. The patient's behavior is influenced not only by his direct relations with other patients, with staff members, or with visitors, but also by the collateral relations of personnel or visitors among themselves(15).

A disturbance which affects the group organization may manifest itself by symptoms localized primarily in one individual.[5]

If we accept the thesis that the hospital serves the patient during the period when he cannot conform to the expected conventions and traditions, then it follows that the patient may leave the hospital at such time as he can conform. This is a somewhat different approach to the functions and goals of the mental hospital.

In the past, the objective of the hospital has been to cure the patient or help him recover or improve. But we know the difficulties of psychiatrists and biometricians who have been trying to define these terms. However, if we view recovery or improvement in terms of the ability of the patient to live in a certain social setting, then we have a yardstick for measurement. Actually, mental hospitals have been using this yardstick for years. We have known that a patient could leave the hospital when he no longer talked or acted in accordance with ideas considered peculiar or morbid by the community at large. How much of the substratum of the mental illness remained, how much the personality was warped underneath, was often unknown as long as the patient conformed to what was considered normal behavior. The writer recalls a schizophrenic woman with whom a really friendly relationship was formed. She said, "If you say that my ideas seem strange to other people, I'll just not talk about them." She stopped talking delusionally and went home as a social recovery from schizophrenia.

Twenty years ago Sullivan(16) had written

A study of social recoveries in one of our large mental hospitals some years ago taught me that patients are often released from care because they had learned not to manifest symptoms to the environing persons; in other words, had integrated enough of the personal environment to realize the prejudice opposed to their delusions. It seemed almost as if they grew wise enough to be tolerant of the imbecility surrounding them, having finally discovered that it was stupidity and not malice. They could then secure satisfaction from contact with others while discharging part of their cravings by psychotic means. The path to social recovery—so often a necessary preliminary to thoroughgoing treatment—thus seemed along the line of really sympathetic environment. . . .

There are some patients who by long and intensive treatment, usually by psychoanalytic techniques, do attain sufficient understanding of their own personality and reactions and do achieve sufficient experiential education to emerge with new facets to their personalities. But we delude ourselves if we think that patients who are leaving our public mental hospitals are people with new personalities. We see indications of this when patients who have been very disturbed and psychotic gradually cease to be so and whose behavior, in time, again approaches the community norm save for a few eccentricities. These patients find their way to the open wards and may be able to leave hospital if a suitable home can be found. In some VA hospitals, up to 35% of the total patient population live on open wards. Although still psychotic, they have learned to adapt to the social structure of the hospital community.

The staffs of public mental hospitals would agree that social recovery of patients from psychosis is more readily and more likely attainable than insightful cure. If social recovery is a major objective, then the hospital must help the patient to learn new or better ways of living harmoniously in his cultural environment and must use ingenuity and resourcefulness to set the stage upon which the drama of new learning may occur.

[5] This statement has been verified in the studies of Stanton and Schwartz in their studies in personnel-patient interaction at the ward level. (Stanton, A. H., and Schwartz, A. S. The Management of a Type of Institutional Participation in Mental Illness. *Psychiatry*, 1949, Vol. 12, pp. 13-26.)

Several recent developments in psychiatry appear promising. Ego psychology furnishes a theoretical background for work in this area.[6] Milieu therapy offers an operational pattern.[7]

Sullivan succinctly wrote:

> The mental hospital . . . [can become] a school for personality growth rather than a custodian of personality failures (17).

THE HOSPITAL AS A SCHOOL

That a hospital may also function as an institution of learning is not a new idea. It was implied in the concepts of moral treatment which sought to provide means to assist and strengthen the patient to control his morbid impulses. The means employed were permissive atmosphere, kindly firmness, regular occupations, and suitable diversions.

Moral treatment had placed great emphasis on the capacity of the patient to help himself. It sought recovery from within by providing and promoting the proper environment. Today we might say that moral treatment developed and increased ego strengths.

When custodial care appeared, the emphasis shifted diametrically. Custodial care was a sheltering envelope which promoted passivity and dependency. It is no wonder so many patients assumed the fetal posture. Under the static environment of custodial care, regression was marked. An individual already crippled by mental disease had limited resources to withstand the atrophying pressures of a custodial hospital.

W. K. Garlington (18), clinical psychologist, and G. K. Hyer, social worker, at VA Hospital, Sheridan, Wyoming, described their experiences of living on a psychiatric ward for a week.

> In the past it was felt that a patient who sat in his chair most of the time staring at nothing was quite ill. We considered him withdrawn and definitely not ready for discharge. Toward the end of our study, both observers found that they were sitting in their chairs staring at nothing. This led to the conclusion that either (1) the observers were becoming withdrawn and were not ready for discharge, or (2) the ward was stimulus that made this kind of response *normal*. The observers felt that spending 24 hours on a fairly active ward led them to appreciate the boredom, monotony, the stifling weight of few associations which add *real* meaning to the statement of many patients: "If I stay here much longer, I'll really go crazy!". . . . The observers began to realize that a patient is faced with an extra problem in trying to get well in a situation so different from his previous environment.

An interesting parallel may be drawn from experiences in institutions for children. Bettelheim and Sylvester (19) report:

> Pathological institutionalism may be regarded as a deficiency disease in the emotional sense. Absence of meaningful, continuous, interpersonal relationship leads to impoverishment of the personality. . . . Only measures arising from benign interpersonal relationships among adults and children can combat the impoverishment of the personalities of children who suffer from emotional institutionalism. . . . Depersonalized rules and regulations lead the child to become an automaton in his passive adjustment to the institution. There is no need for independent decisions because physical existence is well protected and activities arranged for his compliance with stereotyped rules rather than assertive action constitutes adequate adjustment but does not allow for spontaneity. Reality testing is not extended to variegated life conditions. Complete determination by external rules prevents the development of inner controls. The child lives in emotional isolation and physical distance from the adult.

After visiting some 35 mental hospitals, the writer has formed strong convictions that much of the pathological behavior of patients is a result of their hospital experience rather than a manifestation of their mental illness. In some hospitals patients appear very much the same as people outside. They dress neatly, they speak spontaneously, and perceive and respond to their environment. In other hospitals, and fortunately

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[6] Ego psychology has been defined as "the latest development of psychoanalysis [which] permits us to recognize and estimate those features of personality which are molded by the cultural environment and are superimposed upon a more or less uniform biological and emotional substratum." (Alexander, F. Our Age of Unreason, p. 7. New York: J. P. Lippincott, 1952.)

[7] Milieu therapy has been defined as ". . . the procedure directed toward modification of the environmental part of the patient-environment process with a view to facilitating more satisfactory patterns of interaction. It includes all the field of psychiatric therapy outside of these methods designed to modify the functions of the patient otherwise than through communication broadly conceived. It does not exclude psychotherapy which is regarded as part of the milieu. The milieu of man as a physical organism is water, air, food, other men, etc. The milieu of man as a human being has to be described in terms of communications with other human beings." (Rioch, D. McK., and Stanton, A. H. Milieu Therapy in Proceedings of the Association for Research in Nervous and Mental Diseases, 1951, p. 94).

there are few, the patients are the picture of regression, lying on the floor, or with head cast down, untidy, uncaring about personal appearance and habits, oblivious to their surroundings. Two hospitals visited in 1949 were typically custodial. In 1953, both hospitals were visited again. More enlightened administrations had prevailed for several years and the difference in the patients was noticeable in that they were much more alert and responsive although the extent to which they will further improve remains to be seen.

The public mental hospitals in this country have begun to emerge from the long years of custodial care. We have the opportunity to cast a new mold. Studies are in progress to help us find the answer (e.g., the Russell Sage Study on Ward Interaction). History, too, can be useful in pointing the way.

TOWARD THE FUTURE

The concept of the hospital serving as a school for patients to learn to live in society would seem a fruitful one. Few patients are totally disabled; most have some resources and assets that can be developed just as the amputee learns to walk with a prosthesis or the aphasic learns to talk again. It is this process of uncovering and developing inner resources and teaching patients to use them that constitutes an educational program. "The situation is one of education, broadly conceived, not by verbal teaching but by communal experience—good tutoring"(20).

True, there are patients who need a hospital rather than a school: many of the aged, the organically ill, and some of the acutely psychotic. But well over half the patients in a public mental hospital are chronic patients who could profit from such an experience. An important step is acceptance by the staff, patients, relatives, and the community that the hospital has the function of a school as well. This would also make more understandable the genesis and nature of mental illness and indicate the need for everyone concerned to be involved in the treatment (or educational process).

If the hospital is to prepare the patient to return to a family and community life, then the hospital must provide the laboratory for the patient to practice the necessary skills. Bleuler indicated it was preferable to treat patients in their usual surroundings and Ruesch(21) echoes it in the present.

> Therefore it is imperative that a patient should, during therapy and after, lead as normal a life as possible. . . . only conditions which approximate the life situations pertaining to work and play and provide for social intercourse with other people, young and old, and with members of the opposite sex. Though therapy at times has to be carried out in an institution, which prevents the patient from having the usual type of life experiences, the majority of therapeutic procedures ought to be aimed at being carried out within the habitual surroundings of the patient. Isolation in institutions and separation of sexes and age groups facilitate administration but do not necessarily improve the patient.

Our hospitals need to approximate the kind of living conditions found in the usual everyday life of people at large. Nor should it be impossible to adapt hospitals to this end even though patients live in large groups.

A potent obstacle in undertaking new ventures in mental hospitals is the weight of tradition. Attitudes in reference to security furnish a good example. In the past, our limited knowledge and anxious attitudes have dictated security measures which certainly did not permit "normal living." Being furnished only a spoon at mealtimes or having to perform one's toilet functions in full view of others is a far cry from acceptable social manners. Yet suicides and elopements occur in the most secure hospitals. Many of us have learned that security measures are no substitute for alert, interested personnel. But as security measures are loosened they must be replaced by something else, preferably more constructive and useful to the patients. We have indications that the substitute may well be in the security furnished by the bonds of relationship with the staff and with other patients.

The confines of this paper do not permit a discussion of the role of patient-personnel relationships in the hospital's therapeutic mission. Needless to say, they are its foundation stone.[8]

[8] "Since the recovery of patients is more dependent on the interaction of personalities than any other factor, it is our belief that the personnel is the chief asset of the psychiatric hospital and far more important than the hospital equipment." Menninger, W. C. Psychoanalytic Principles in Hospital Therapy, Southern Medical Journal, 1939, Vol. 32, pp. 348-352.

SUMMARY

We are perhaps now in psychiatry where physicians treating infectious disease stood before the days of antibiotics. We have relatively little in the way of weapons to attack the disease process directly. But we have acquired a vast and important knowledge of how to promote and how to provide conditions favorable for the living effort of the human organism to make itself whole. This knowledge can make the difference between very favorable and very unfavorable discharge rates.

Here is a point at which the values of democracy, religion, and medicine agree—the value and dignity of the individual, the value of human understanding and of kindly relations with and assistance to another person, who must himself continue his unremitting struggle to find an adjustment and meaning in his life.

While we strive to go forward toward more definitive methods of treatment, however much they may extend our success, they can never replace for the mental patient—as for the normal person—the need for understanding, constructive, human exchange.

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HISTORICAL NOTE

I REMEMBER KRAEPELIN

"Sie Wünschen?" I was in the presence of the greatest psychiatrist of his time, the man to learn from whom I had crossed the wide ocean—it was wider in those days. His two words were not quite a greeting and not entirely reassuring.

That morning after securing lodging on the *Anlage,* where I was to live for the next two years, I had started out bravely with letters of introduction in my pocket. Following the *Hauptstrasse* toward the east end of town I reached the *alte Brücke,* called by Goethe the most beautiful bridge built by man. *Alt Heidelberg* is a small city stretched along the south bank of the west-flowing Neckar and sheltered on the south by the imposing *Königstuhl* up the sides of which it timidly pushes its way. The *alte Brücke,* like Arno bridges, was a victim of senseless Nazi fury, but it has been faithfully restored. Across the river following directions I soon located Kraepelin's house on the *Uferstrasse,* and making my errand known at the door, was shown into his study. Kraepelin was sitting at his desk and scarcely looked up. *"Sie wünschen?"* was his total salutation. I stumbled through the halting German I had rehearsed on the way over. *"Herr, Professor, Ich habe Briefe an Sie."* He took the letters, read them slowly and at once became affable. The sponsors were apparently satisfactory. The interview did not last long, but there was no feeling of haste. Kraepelin leisurely outlined the activities of the hospital —the *Universitäts Irrenklinik*—the lectures, ward rounds, clinics, and laboratory facilities, and named the heads of departments with whom one might register for special work. There was no fee; all that was necessary to bring was the purpose to work and to learn.

The clinic was and is located just above the river bank at the west end of the town—a long low two-story building paralleling the river. A dignified façade was assured by a three-story central block.

At this point, one vivid memory interjects itself irrelevantly. As I was leaving Nissl's laboratory one night some time after the dark had settled down and all was quiet, a clear tenor voice broke out from the men's division singing the lovely *Abschiedslied jung Werners* from *Der Trompeter von Säkkingen:*

Das ist im Leben hässlich eingerichtet,
Dass bei den Rosen gleich die Dornen stehen,
Und was das arme Herz auch sehnt und dichtet,
Zum Schlusse kommt das Voneinandergeh'n . . .

One could not abide long in Heidelberg without falling under the influence of Victor von Scheffel and his exquisite dramatic poem in which this sad parting song occurs. The singer was apparently standing at an open window overlooking the river. It was as if he were singing passionately to some listening Ondine of the Neckar. The lines of his song I already knew by heart. He sang it through to the end:

Behüt' dich Gott! es wär'zu schön gewesen,
Behüt' dich Gott, es hat nicht sollen sein!

and I could not leave the spot until the song was done and quiet came again.

There were three senior men on Kraepelin's staff—Nissl, Alzheimer, and Gaupp. The latter, youngest of the three, survived his colleagues, dying only in August 1953. He was an honorary member of The American Psychiatric Association. Wilmanns and Nitche were also attached to the clinic and there were one or two junior members as well.

Ward rounds with Kraepelin were most impressive. One was reminded of similar experiences with Osler. There was a like meticulous scrutiny of the patient and his reactions, the details of his behavior, his responses, his spontaneous productions. Discussion was invited. There was nothing static or authoritarian about Kraepelin's teaching. He set up no system which must then be fortified and defended. Those gathered about

him were not only free but were urged to make their own contributions. He digested them all. Sometimes an opinion would be brought forward quite contrary to one he had held. After full discussion he might agree that the new view was more likely the correct one. This flexibility of mind and utter lack of dogmatism could not fail to create the highest respect for Kraepelin's teaching methods and for his psychiatric judgments. He impressed upon his students that psychopathology was always in process, nothing was fixed or final. An expression of his was *"Wir stehen immer noch am Anfang."* The evolution of his textbook, which became the most extended, comprehensive psychiatric treatise ever put together by one man, reflected the extraordinary development of this branch of medicine during what may justly be called the Kraepelinian period. It began with his *Compendium der Psychiatrie* (1883), a pocket-sized manual hardly three-quarters of an inch thick, published when Kraepelin was Dozent at the University of Leipzig. The ninth edition, incomplete at the author's death in 1926, consisted of four large volumes, the first two volumes revised, the last two reprinted from the eighth edition, the whole running to 2,372 pages.

In mid-twentieth-century writing the psychiatry of Kraepelin is sometimes depreciatingly referred to as "descriptive," as if somehow description were not essential. "Complete description is complete interpretation." In his fine memorial of Kraepelin Adolf Meyer wrote:

> Through him, diagnosis in psychiatry has become more than description. It committed the physician to certain implications, no doubt oversimplified in the minds of many, but definite and important implications of prognosis. . . . The Heidelberg clinic at that time was the center of work on 'processes.' The psychological experiment and the clinic alike dealt with processes, *i.e.*, specific modifications of structure and function, that might be underlying specific diseases. The static, purely descriptive period had come to an end. . . . The broadening of Kraepelin's viewpoint shown in his *Erscheinungsformen des Irreseins* softened the extreme contrasts between nosological rigidity and the freedom of the reaction-type psychiatry without any great influence upon those who had once and for all accepted the original simplification of diagnosis by classification.

The truth is that the views of Kraepelin were continually undergoing change as new facts came to light and new viewpoints to expression. This the successive editions of his textbook abundantly prove. Adolf Meyer stressed the point: "Every edition of his work is to an unusual extent like the work of another man."

Kraepelin came to Heidelberg from Leipsig where he had been associated with Wundt, the creator of the psychological laboratory, and he combined psychological with clinical work from the beginning. He fitted up a small laboratory for psychological investigations at the Heidelberg clinic and published in an extended series the *Psychologische Arbeiten* wherein are recorded his own experimental studies and those of his colleagues and students. Gaupp was in immediate charge of the psychological laboratory, as Nissl was of the neuropathological.

Kraepelin's nature was somewhat less outgoing than Nissl's but he was no less friendly and painstaking with his staff and students. He took part also in their extracurricular activities, although he never accompanied us on a *Bierreise* as Nissl on occasion might do. Kraepelin was an *Abstinenzler* (of this later).

One of our most enjoyable recreations was the planned *Spaziergang*. Kraepelin, Alzheimer, Nissl, Gaupp, several senior staff members, visiting colleagues, and graduate students, forming a small party of a dozen or so, would spend an afternoon tramping through the mountains and forests, usually along the well-beaten trails cushion-carpeted with years' deposits of pine needles, following guide boards which indicated that this or that path led to the *Wolfsbrunnen*, the *Felsenmeer*, or one of the other spots of beauty or grandeur with which the Neckar valley abounded. The terminus of these walks would be a *Gasthaus* where beer was never so welcome and conversation flowed freely about persons and places, bits of local history or folklore, what was going on in the learned world; even a snatch of shop talk might creep in.

Those were the "Golden Days" of the song in *The Student Prince*, the original of which, *Alt Heidelberg*, had just come on the boards in all the theatres in Germany. It was a time of peace and *Gemüthlichkeit* unclouded by any apprehension that this way of life that

we from the *Ausland* had come to know and to love would within a decade come to an end and be no more.

One final nostalgic recollection. Kraepelin gave a New Year's Eve at home party for his clinic staff. He and his gracious wife and two comely daughters were most solicitous to make their guests comfortable and at ease. Near the entrance to the drawing room where we gathered was a well-filled punch bowl which looked reassuring, and presently the young ladies proceeded to distribute the cups, refilling them as occasion required. No comment had been offered as the nature of this punch, but we found to our sorrow that it was composed solely of fruit juices. It was very palatable but innocent of any euphoric quality. Refills were not in so frequent request as they might have been.

Dinner was set at an hour later than usual for this was New Year's Eve and we were bidden to watch the old year out. Summoned at length to the dining room a gorgeous spectacle awaited us. The table occupied nearly the length of the room and in the center a mountain had been built up of a variety of fruits. In this delectable mountain were embedded several bottles of wine. At last, the reward! Dinner was not far along when Kraepelin remarked, "As you know, I am an abstainer and alcoholic beverages are not used in our family, but if any one would like to partake of the wine he may feel quite free to do so." It was not exactly an invitation and no one felt moved to express a bibulous desire. I do not recall that any tool for lifting the corks was in evidence. There was this splendid mountain of fruit and wines just within reach and yet really out of bounds. It was merely a center piece, grand to look at but recalling the tortures of Tantalus. Was it perhaps just another of the Herr Professor's psychological experiments?

The feast was sumptuous and we sat long at table, but there was something lacking—that subtle something of vinous origin that a Quebec friend once characterized as *"le chaleur communicative du banquet."*

Dinner over, we returned to the drawing room for further conversation awaiting the stroke of twelve. The clocks seemed to be losing time that night. Eventually midnight came. All the bells of the city announced with joyous clamor the mystic hour. We were all on our feet at once; there was handshaking all round, and many a *glückliches Neujahr*. Our hosts gave each of us their blessing; we them our homage and gratitude, and the party was at an end.

To have dined with the family Kraepelin, and on such an occasion, was indeed something for enduring memory.

I hope it is not out of order to add that it did not seem unfit, before returning to quarters that night, to pause at some *Bierhalle* for a stein of *Löwenbrau* as a sort of epilogue to a memorable evening.

C. B. F.

SCIENCE

When we speak of science we are not thinking merely of the mechanical and technical accomplishments whereby it transforms the material conditions of living. For we believe that science, in the true and original sense of the term "to know," attains its greatest efficacy when it brings to the clear light of human understanding the true meaning of humanity's most cherished values and the means of preserving them. . . .

—Shih-Hsiang Chen,
The Cultural Essence of Chinese Literature

CORRESPONDENCE

THE CONCEPT OF SCHIZOPHRENIA

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Last March the thought occurred to me that it might be worthwhile to obtain an opinion from Professor Manfried Bleuler as to the diagnostic criteria which had been established at Burghölzli with reference to the diagnosis of schizophrenia, schizoid states "pseudoneurotic schizophrenia," and allied conditions. This area was so confused that it seemed to call for an authoritative approach to set up some sort of diagnostic standards. The traditions at Burghölzli, where the concept of schizophrenia and allied conditions had originated, would appear to claim respectful attention. Unquestionably today, and especially in this country, the concept of "schizophrenia" has become adulterated to the point where it has become meaningless and in some cases practically equivalent to "psychotic."

Enclosed is my translation of Professor Bleuler's reply to my letter which I thought might be of sufficient interest to warrant publication. Professor Bleuler has given his permission for its publication.

HIRAM K. JOHNSON, M. D.,
Orangeburg, N. Y.

Zurich, March 26, 1954.

HIRAM K. JOHNSON, M. D.,
Clinical Director,
Rockland State Hospital,
Orangeburg, New York.

DEAR SIR:

Your letter of December 2 touches upon a problem concerning which I feel deeply. Naturally enough, a book could be written concerning this subject. However, quite briefly, may I emphasize merely the following points:

I.

The expression "schizophrenia," not only as it was coined by my father, but as it was taken over by Kraepelin and many others, claims to denote a definite psychosis. It is difficult to define the concept "psychosis" exactly. In this definition there must be emphasized always the potentiality for intellectual and emotional rapport, of lucidity and empathy. The distinction of psychoses from other mental and emotional disturbances may not be very important medically. However, it is certain that it has the greatest importance sociologically, legally, and in popular terminology.

According to my conviction it can only lead to confusion if the term "schizophrenia" is used for those less serious mental disturbances which are not psychoses. I, myself, in general, employ "schizophrenia" only for those disturbances which are unquestionably psychoses in terms of social adjustment.

II.

It is true that my father surmised that many disturbances are concealed in the clinical picture of the psychopathies and neuroses, which in their origin and in their essence could be regarded like schizophrenia. But to avoid an error in terminology these disturbances should never be spoken of simply as "schizophrenia", but more exact descriptive paraphrases should be used, for example: "latent schizophrenia" "schizophrenia which has not shown up yet in social adjustments"; "socially adjusted schizophrenia"; "neuroses suspicious of schizophrenia"; "psychopathies which are suspicious of schizophrenia"; "conditions suggesting incipient schizophrenia"; "conditions suggesting a residual following genuine schizophrenia", etc.

III.

I believe it is entirely incorrect to consider the concept "schizoid" the same as "schizophrenia." First of all, the schizoid psychopaths and schizoid behavior (both included together as "schizoids") according to the degree are not psychoses but peculiarities of personality or personality pattern disturbances. The relationship between "schizoid" and "schizophrenia" follows from these facts: Many schizoid character traits re-

semble somewhat the symptoms which, in schizophrenia, are blown up to psychotic proportions (on the other hand, all the symptoms of schizophrenia are not found in schizoids); in the prepsychotic personalities of schizophrenics there are many more schizoids than in the general population; after schizophrenic episodes often follows a change of personality in a schizoid direction; among the relatives of schizophrenics there are many more schizoids than in the general population. These grounds are not sufficient, however, to assume that "schizoid" and "schizophrenia" are identical, even if some genetic relationship is probable. The nature of this genetic relationship remains as something to be cleared up.

IV.

The term "pseudoneurotic schizophrenia" appears to me as useful. What is meant here is unmistakably characterized; a condition which is schizophrenia essentially, but in terms of social adjustment has not reached the level of a schizophrenia but simply that of a neurosis. With Hoch I am convinced that there are pseudoneurotic schizophrenias, and my father has already emphasized this.

V.

The confusion of terminology is largely conditioned by the fact that some authors think only psychoanalytically, while others day in and day out, deal with the psychosis concept as one concerned with social adjustment. In the psychoanalytic conception it is entirely right to perceive in many schizophrenic processes fundamentally the same thing as in neurotic and normal processes—already Jung and my father referred to this. But, if on the basis of a diagnosis of "psychosis" practical decisions have to be made (accountability, judgment, the appointment of a guardian, the ability to contract a marriage, certifiability etc.), then the older psychosis-concept becomes necessary, and one should not use this psychosis-concept for conditions which have an entirely different significance.

In brief, I would reserve the concept "schizophrenia" simply for psychotic conditions. One should not simply denote as "schizophrenia," those conditions which one must assume are identical with (real) schizophrenia in their genesis but which have not advanced to the level of a psychosis. Rather, one should append a descriptive expression to characterize what is meant. The concept "schizoid" should most emphatically be separated from the concept of "schizophrenia."

PROF. M. BLEULER,
Psychiatrische Universitätsklinik,
Zurich, Switzerland.

TERMINOLOGY

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: The very phrase "electroshock" or "electric shock" therapy frightens people. Shock connotes the collapse of function just prior to death. Or it connotes terror. It is a grim joke that we have come to use that word for a soothing and solacing procedure when the word itself carries such overtones of panic.

Nor are "electronarcosis" or "electroconvulsive" much better. The word "narcosis" carries implications of drug addicts, and the word "convulsive" conjures images of "fits." These are, to be sure, lay interpretations of "shock," "narcosis," and "convulsions." But it is a peculiar duty in our discipline that we earn and retain public understanding.

Perhaps "electrosleep" or "electric sleep" therapy might do. It is a bit misleading, but not too much so. However it rings no bells.

I suggest that we call it "electronic therapy." There are, first, no negative connotations in the word "electronic." Second, it is a word that suggests something modern, something up-to-date and, frankly, something almost magical. I do not think that the electronic engineers would object. I do not know how new words are born into psychiatry. But if there are any readers who have the authority to preside at a verbal accouchement, let them consider the possibility of delivering the phrase "electronic therapy" to replace these older and more frightening ones. After all, we did abandon such fear-provoking labels as "'insane" and "asylum." Why must we carry the added burden of words like "narcosis" and "shock"?

HENRY A. DAVIDSON, M. D.,
Cedar Grove, N. J.

PRIVILEGED COMMUNICATIONS

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: In the July 1954 issue of the JOURNAL, pp. 13-14, there is a statement, under the "Section of Legal Aspects of Psychiatry, Summary of Symposium of Privileged Communications," as follows:

> In Germany and Austria, for example, the doctor is not only required to testify in criminal cases, but is obliged to notify authorities of any cases in which he suspects homicide, for example. This was true long before the Nazis came into power.

This formulation must create in the reader the erroneous impression that in pre-Hitler Germany, the professional secrets of his patients were not protected when a physician was called into court. On the contrary, the *Reichs-Straf-Gesetzbuch,* the basic criminal law for the German Reich, had in its Section 300 definite provision concerning privileged medical communications. In addition, the *Ehrengerichte, i.e.,* legally instituted grievance committees with extended legal powers, which were attached to the legally instituted *Aerztekammern,* supervised, and, if necessary, punished physicians for neglectfully divulging secrets—even in court. The *Aerztekammern* also functioned as advisors and consultants for the courts in questions of privileged communications.

I was, until 1933, an elected member of the executive committee (Presidium) of the *Aerztekammer* for Greater Berlin.

WILFRED C. HULSE, M. D.,
New York City.

PROGNOSIS

> While, then, the hospitals continue their progress in the fulfilment of their beneficent mission, it would appear that the better course for the superintendents is to discard, universally, as they already have discarded, to a great extent, the classification of their cases according to duration; but constantly to keep before the people the great truth that, as a rule having comparatively few exceptions, the sooner the person attacked with insanity is placed under curative treatment, the greater is the prospect of recovery.
>
> —PLINY EARLE,
> *The Curability of Insanity* (1887)

OFFICIAL NOTICE

The subjoined "Resolution on the Relations of Medicine and Psychology" was composed jointly by the special committees of the American Medical Association, The American Psychiatric Association, and the American Psychoanalytic Association for the purpose of presenting a united front to the effect that psychotherapy is a form of medical treatment in accordance with medical criteria and that it is not a precedure justifying a separate profession.

This resolution has been approved for publication by the Board of Trustees of the American Medical Association, the Council of The American Psychiatric Association, and the Executive Council of the American Psychoanalytic Association.

RESOLUTION ON RELATIONS OF MEDICINE AND PSYCHOLOGY

For centuries the Western World has placed upon the medical profession responsibility for the diagnosis and treatment of illness. Medical practice acts have been designed to protect the public from unqualified practitioners, and to define the special responsibilities assumed by those who practice the healing art, for much harm may be done by unqualified persons, however good their intentions may be. To do justice to the patient requires the capacity to make a diagnosis and to prescribe appropriate treatment. Diagnosis often requires the ability to compare and to contrast various diseases and disorders which have similar symptoms but quite different causes. Diagnosis is a continuing process, for the character of the illness changes with its treatment or with the passage of time and that treatment which is appropriate may change accordingly.

Recognized medical training today involves, as a minimum, graduation from an approved medical school and internship in a hospital. Most physicians today receive additional medical training, and specialization requires still further training.

Psychiatry is the medical specialty concerned with illness having chiefly mental symptoms. The psychiatrist is also concerned with mental causes of physical illness, for we have come to recognize that physical symptoms may have mental causes just as mental symptoms may have physical causes.

The psychiatrist, with or without the consultation with other physicians, must select from the many different methods of treatment at his disposal, those methods which he considers appropriate to the particular patient. His treatment may be medicinal or surgical, physical (as electroshock) or psychological. The systematic application of the methods of psychological medicine to the treatment of illness, particularly as these methods involve gaining an understanding of the emotional state of the patient and aiding him to understand himself, is called psychotherapy. This special form of medical treatment may be highly developed, but it remains simply one of the possible methods of treatment to be selected for use according to medical criteria for use when it is indicated. Psychotherapy is a form of medical treatment and does not form the basis for a separate profession.

Other professional groups such as psychologists, teachers, ministers, lawyers, social workers, and vocational counselors of course use psychological understanding in carrying out their professional functions. Members of these professional groups are not, thereby, practicing medicine. The application of psychological methods to the treatment of illness is a medical function. Any physician may utilize the skills of others in his professional work, but he remains responsible, legally and morally, for the diagnosis and for the treatment of his patient.

The medical profession fully endorses the appropriate utilization of the skills of psy-

chologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians. It further recognizes that these professions are entirely independent and autonomous where medical questions are not involved; but when members of these professions contribute to the diagnosis and treatment of illness, their professional contributions must be coordinated under medical responsibility.

WALTER B. MARTIN, M. D., *President, American Medical Association.*
ARTHUR P. NOYES, M. D., *President, American Psychiatric Association.*
IVES HENDRICK, M. D., *President, American Psychoanalytic Association.*

EUGENICS

Man is gifted with pity and other kindly feelings; he has also the power of preventing many kinds of suffering. I conceive it to fall well within his province to replace Natural Selection by other processes that are more merciful and not less effective.

This is precisely the aim of Eugenics. Its first object is to check the birth-rate of the Unfit. . . . The second object is the improvement of the race by furthering the productivity of the Fit. . . . Natural Selection rests upon excessive production and wholesale destruction; Eugenics on bringing no more individuals into the world than can be properly cared for, and those only of the best stock.

RACE IMPROVEMENT

It would be easy to add to the number of possible agencies by which the evolution of a higher humanity might be furthered, but it is premature to do so until the importance of attending to the improvement of our race shall have been so well established in the popular mind that a discussion of them would be likely to receive serious consideration.

—FRANCIS GALTON

COMMENT

A MATTER OF HISTORICAL PERSPECTIVE

"The physician should know what the physician before him has known if he does not want to defraud himself and others."—Hippocrates

What do the young and middle-aged psychiatrists of today know about the major contributors to the facts and theories that have influenced the development of our specialty? An attempt was made to satisfy this curiosity by sending the following letter to a number of persons in charge of psychiatric hospitals:

For some time, I have been interested in an attempt to ascertain the scope of "background orientation" on the part of the younger-generation psychiatrists. I feel that the teaching of contemporary attitudes and theories is improving steadily and there is a reasonably good appreciation of the people who have introduced or advocate modern ideas and practices. However, I am not sure about the younger group's awareness of contributions to our field of knowledge made by the "giants" of the era immediately preceding the newcomers of today.

I have tried to find some way which might give me the desired information that might—if adequate—serve as a stimulus to some suggestion regarding the introduction of a modicum of historical considerations in a psychiatric teaching program. It has occurred to me that it might perhaps be the easiest and least time-consuming way to submit during a staff conference a list of names to the staff members present, asking them to check those names with which they are familiar and those which have no meaning to them and also to state in a few words the outstanding contribution of the person named. The list is then to be returned at the same session to the person who presides.

I wish to make it clear that the participants are not to sign their names to the sheet and that there will be no mention or comparison of the places from which the returns will come. The purpose is definitely not one of singling out any individuals or schools but to get a general survey of the knowledge of psychiatric history on the part of the young specialists of our day. . . .

Reports have come in from 17 centers which include 11 university hospitals, 3 veterans administration units, 2 publicly supported institutions, and one large private hospital, all of which have training programs. In addition, the list was submitted at a regional meeting attended by residents and by privately practicing psychiatrists. A total of 294 individual sheets were thus made available for the survey. The range of experience extended from first year residency all the way to "board-eligible" and "board certified."

The scoring was lenient. Any indication that a name meant anything to the person tested, even the most general identification (*e.g.*, Bernheim—hypnosis, Janet—hysteria, Piaget—children), was considered as meriting a plus score.

While the list was presented alphabetically, it is reproduced here in the order of the frequency of plus scores obtained for each name:

Sandor Ferenczi	263
Karl Abraham	250
Carl Wernicke	227
Pierre Janet	184
Wilhelm Stekel	174
Hippolyte Bernheim	152
Daniel Tuke	151
Julius Wagner von Jauregg	135
Morton Prince	111
Jean Piaget	102
Karl Kahlbaum	91
Ewald Hecker	60
Gustav Aschaffenburg	29
Karl Bonhoeffer	29
Karl Kleist	28

There were 1,986 positive identifications out of an ideal total of 4,410. All 15 men were known to five persons, 14 to four, 13 to eight, 12 to nine, 11 to twenty, and 10 to twelve.

A few incidental observations are of interest. Nine mistook Kahlbaum for Kallmann ("genetics," "twin studies in schizophrenia"), 9 thought of Sakel when they saw Stekel ("insulin," "coma," "ECT"), 3 credited Jauregg with the introduction of metrazol treatment or ECT, one wrote

"ECT" after Ferenczi, one believed that Prince was Prinzhorn ("art of the insane"), and one connected Kleist with Klages ("graphology"). Not less than 100 could say nothing more of several men than that they were adherents, opponents, coworkers, predecessors, or contemporaries of Freud (often incorrectly): 55 said this of Janet, 31 of Bernheim, 6 of Prince, 5 of Jauregg, 2 of Wernicke, and one of Kahlbaum.

It is possible to argue that a more appropriate list might have been selected; the one submitted was checked carefully with Dr. Owsei Temkin, the Johns Hopkins medical historian, who teaches an excellent course on nineteenth century psychiatry. Be this as it may, it is remarkable that, with the exception of Wernicke (most annotations say, "Wernicke's syndrome") and of Janet, the list is topped by the analysts Ferenczi, Abraham, and Stekel, and that Bernheim follows closely because of his association with the Nancy school. The numbers then dwindle rapidly.

Does this mean that the analytic group has done a better job than the rest of us in propagating an appreciation of earlier contributors? If so, have we not failed in our teaching of the significance of the work of some of the pioneers of our specialty? Does not this survey force us to conclude that we ought to introduce a better historical perspective in our training programs?

Goethe has said: "The history of a science is the science itself." The history of psychiatry did not begin when the younger generation joined the profession. Might we not bring this to the attention of the newcomers whom we are called upon to teach?

L. K.

BELIEF

There is no harder scientific fact in the world than the fact that belief can be produced in practically unlimited quantity and intensity, without observation or reasoning, and even in defiance of both by the simple desire to believe founded on a strong interest in believing. Everybody recognizes this in the case of the amatory infatuation of the adolescents who see angels and heroes in obviously (to others) commonplace or even objectionable maidens and youths. But it holds good over the entire field of human activity. The hardest-headed materialist will become a consulter of table-rappers and slate-writers if he loses a child or a wife so beloved that the desire to revive and communicate with them becomes irresistable.

—Bernard Shaw.

THE SOCIETY OF BIOLOGICAL PSYCHIATRY

In response to a number of requests from members of The American Psychiatric Association, this article is written in order to inform its members concerning the historical background, origins, purposes, functions, and activities of the Society of Biological Psychiatry.

HISTORY AND ORIGIN

In the spring of 1945, two of the founding members of the Society were completing the manuscript of a new textbook of psychiatry. In this book the authors had attempted not only to emphasize the currently popular psychogenic aspects of psychiatric disorders but also had attempted to trace the known facts of cerebral anatomy and physiology as applied to mental disorders. In their discussions they agreed that there existed no group or organization where this phase of psychiatric research was emphasized, and by mutual consent they decided to attempt the organization of such a group. A small number of interested workers was contacted and the founding meeting was scheduled to be held in the summer of 1945 in Chicago. The early days of the Society's existence were beset with difficulties, however, and the railway strike of 1945 prevented the holding of the first meeting. This was then postponed until the summer of 1946, when a meeting was called by the acting chairman, Dr. J. M. Nielsen, and the first meeting was held at the Fairmont Hotel in San Francisco on June 27, 1946.

The founding members were Drs. Percival Bailey and Roland P. Mackay, of Chicago; Drs. Harry C. Solomon and Stanley Cobb, of Boston; Dr. Samuel B. Wortis, of New York; Dr. Karl M. Bowman, of San Francisco; and Drs. J. M. Nielsen, Samuel D. Ingham, and George N. Thompson, of Los Angeles. It is of interest that all held professorial or associate professorial rank at their respective universities, indicating academic activity as one of the functions of the Society. Dr. Nielsen was appointed acting chairman and the year following became the group's first president. At the organizational meeting many problems had to be considered, including the naming of the new society. After much consideration, the name Society of Biological Psychiatry was chosen, since biology in all of its aspects is the foundation stone of the organization. It was not the intent of the founders to detract from the value of psychology since all had extensive backgrounds in this field. Rather it was intended to emphasize biology, since biology is the basic science and psychology is one of its branches.

STATEMENT OF PURPOSE

Research was considered to be the most important function of the Society, and from the beginning the founders determined that membership would be limited to those who engaged in biological research as related to psychiatry. An early basic principle of the Society was that it was to be entirely nonpolitical in its activities. It is of considerable interest that at the Society's second meeting, held in 1947 in Atlantic City, the secretary was approached by Dr. A. B. Baker, professor of neurology at the University of Minnesota. Dr. Baker expressed the opinion that the Society should become a large, partly political organization which would offer a common meeting place for neurologists, just as The American Psychiatric Association does for psychiatrists. When Dr. Baker, who soon became a member of the Society, was told of the limited scope (research) and nonpolitical nature of the Society, he recognized that the group was for both neurologists and psychiatrists. It was suggested to him that he contact a large number of neurologists, whereupon he returned to Minneapolis and promptly organized the American Academy of Neurology. Thus in a sense the Society of Biological Psychiatry is partly responsible for, and may be said to have given impetus to, the organization of the American Academy of Neurology.

The Society of Biological Psychiatry is composed of individuals, mainly physicians, in the fields of neurology, psychiatry, psy-

chology, neurophysiology, electroencephalography, neuroanatomy, neurosurgery, neuropathology, and neurochemistry who are interested in the biological basis of behavior. Many of the members are solely research workers and some are clinicians, but a research background is a requirement for every member. The membership is now limited to 150 (originally 100) and is international in scope. Individual membership is contingent primarily upon the research work that a prospective member has done concerning the neuronal basis of human behavior; the activities of the organization are fundamentally devoted to this phase of neuropsychiatric research. All of the members are men and women who have contributed substantially to the sum of scientific knowledge and have published significant findings. Membership is initiated by the invitation of a member who is not an officer of the Society.

The Society of Biological Psychiatry does not concern itself with anything but the scientific side of the problems of psychiatry and particularly its neuronal basis in all its aspects. The concept of the neuronal basis of psychiatry is not at all new. Meynert, Wernicke, Bastian, Flechsig, Hughlings Jackson, Kleist, and Henschen made immense contributions to the concept in the nineteenth century. MacDougall postulated that all hallucinations were due to activation of the cerebral areas of representation (recall). Flechsig bemoaned the contempt with which authors of textbooks of psychiatry in the latter part of the last century regarded neuroanatomy. During the last 25 years, especially in this country, even greater advances have been made. Frontal lobectomy, prefrontal lobotomy, the experiments showing the importance of the frontal lobes (by virtue of their hypothalamic connections) in the neuronal patterns of emotions, Nielsen's emphasis of the importance of the cingulate gyrus, the work of Bailey and Davis on the neuronal patterns of conation, the works of Pötzl on the functions of the occipital lobes, and the work of Schilder on the body scheme may be cited. All of the men who served as the nucleus of the Society when it was first formed have contributed to our knowledge of the anatomy of the mind.

Psychiatry has built an enormous culture, an enormous superstructure of observations and interpretations. Those who seek to advance the biological concept wish only to build a foundation under that superstructure and not to detract from the important contributions of psychopathology. They wish to add substance to psychological concepts and to trace the anatomical structures which make these concepts possible. Neurochemistry is considered an essential element of mental function. In biological psychiatry the mind remains in the body and particularly in the brain. The brain is the organ of the mind (Bastian, 1880).

FUNCTIONS AND ACTIVITIES

In order to relate more closely the activities of its psychiatric and neurologic members, the Constitution of the Society provides that it shall meet annually on the day preceding the convention of the American Neurological Association or The American Psychiatric Association, although not necessarily alternately. It has met five times in Atlantic City and one time each in San Francisco, Washington, D. C., Detroit, and Los Angeles. The next meeting will be held on Sunday, June 17, 1955, at the Palmer House in Chicago.

Convention activities include the presentation of papers and scientific exhibits, a President's reception, and an annual dinner. Papers presented at the meeting are published in a special Society of Biological Psychiatry number of *The Journal of Nervous and Mental Disease* each November. Some consideration is being given by the Society to the publication of its own journal, for the research work of its members is mounting rapidly. A typical symposium was the one presented at the 1951 meeting in Atlantic City on "The Anatomy and Physiology of Thought Processes."

Some philanthropic activities are undertaken by the Society, including its annual contribution to the National Society for Medical Research. Of its active members six are women; and although doctors of medicine predominate, many of the members hold the degree of Ph. D. The Society

of Biological Psychiatry was incorporated as a nonprofit corporation in California on January 3, 1949. Its presidents have been Dr. J. M. Nielsen (1946-48), Dr. Percival Bailey (1948-49), Dr. S. B. Wortis (1949-50), Dr. Harry C. Solomon (1950-51), Dr. Roland P. Mackay (1951-52), Dr. A. E. Bennett (1952-53), and Dr. L. J. Meduna (1953-54). Dr. Harold E. Himwich was elected president for the year 1954-55. Other officers for 1954-55 are Dr. Howard D. Fabing, first vice-president, Dr. Margaret A. Kennard, second vice-president, and Dr. George N. Thompson, secretary-treasurer.

GEORGE N. THOMPSON, M. D.,
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G. P. I.

Paralytic affections are a much more frequent cause of insanity than has been commonly supposed, and they are also a very common effect of madness. . . . Persons thus disordered are in general not at all sensible of being so affected. When so feeble, as scarcely able to stand, they commonly say that they feel perfectly strong, and capable of great exertions. However pitiable these objects may be to the feeling spectator, yet it is fortunate for the condition of the sufferer that his pride and pretensions are usually exalted in proportion to the degradation of the calamity which affects him. None of these patients have received any benefit in the hospital; and from the enquiries I have been able to make at the private mad-houses where they have been afterwards confined, it has appeared, that they have either died suddenly, from apoplexy, or have had repeated fits, from the effects of which they have sunk into a stupid state, and gradually dwindled away.

—JOHN HASLAM,
Observations on Madness and Melancholy (1809)

NEWS AND NOTES

Dr. H. C. Woolley.—The death of Dr. Herbert C. Woolley occurred August 28, 1954, at the age of 73, at his home in Sea Girt, N. J. Dr. Woolley was graduated in medicine from Jefferson Medical College, Philadelphia, in 1904. After a period of private practice and graduate work in psychiatry, he joined the staff of St. Elizabeths Hospital, Washington, D. C., where he served from 1924 to 1937, first as clinical director and later as assistant superintendent. In 1938, he was appointed superintendent of Philadelphia State Hospital, serving in that capacity for 3 years. He was a highly qualified administrator and guided the activities of the hospital with military precision. He was also expert in planning and building operations.

During World War I, Dr. Woolley served as medical officer for 3 years, during which he was assigned to duty as post surgeon at Fort Davis, Alaska, and also at Fort Sill, Oklahoma. For a period he was military commander of an area in occupied Germany; and at one time he was commanding officer of the 364th Medical Regiment.

Dr. Woolley's special avocation was sailing. After his retirement from medical practice in 1942 he spent much time on the Florida coast living in his yacht.

Dr. Charles A. McKendree.—The death of Dr. McKendree in his sixty-eighth year occurred September 10, 1954, at the home of his son, Dr. Charles G. McKendree, in Greenwich, Conn.

Dr. McKendree, a native of New Hampshire, a graduate in Arts from Dartmouth College and in medicine from Dartmouth Medical School, had been practicing neurology and psychiatry in New York City since 1915. In that year he joined the staff of the College of Physicians and Surgeons, Columbia University, reaching the status of clinical professor of neurology. He held various other clinical and teaching posts in the city and neighborhood. He was a diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American College of Physicians. He had been a member of The American Psychiatric Association since 1938.

Dr. McCartney on Speaking Tour Abroad.—Dr. James L. McCartney, Garden City, N. Y., has been invited to speak, under the auspices of the World Medical Association, to the medical societies at Havana, Cuba; Yokohama and Kobe, Japan; Manila, P. I.; Colombo, Ceylon; Cochin and Bombay, India; Karachi, Pakistan; Naples and Genoa, Italy. His subject will be "The Treatment of the Involutional and Senile Psychoses." He is leaving New York November 20 and will survey the psychiatric facilities in each of the 14 countries he will visit, returning to New York on March 6, 1955.

Third International Congress on Criminology.—This Congress, under the chairmanship of Dr. Denis Carroll, president of the International Society for Criminology and consultant psychiatrist, Portman Clinic, will be held in London, September 11-18, 1955. The main subject will be recidivism. It will be studied under 5 headings: (1) Definition and Statistics; (2) Forms of Recidivism; (3) Causes; (4) Prognosis; (5) Treatment. It is expected that 1 day will be devoted to each of the headings.

The fee for full membership is £7.7.0. sterling; for associate membership, £2.2.0. All communications concerning the Congress should be addressed to The Organizing Secretary, Third International Congress on Criminology, 28 Weymouth Street, London W.1, England.

Anthropology of the American Southwest.—The August issue of the *American Anthropologist*, the Journal of the American Anthropological Association, contains a symposium, "Some Problems in the Physical Anthropology of the American Southwest." The symposium includes 11 papers by leading anthropologists on ethnology, linguistics, culture and personality, in-

tercultural relations, and other phases of anthropology.

This is the first issue in the 60-year history of the *American Anthropologist* to be devoted to a single area, covering the subject comprehensively. The address of the Executive Secretary is Box 71, Andover, Mass.

NORTHWEST INSTITUTE ON GERONTOLOGY AND GERIATRICS.—The first Northwest Institute on Serving the Needs of our Aging Population will be held at the University of Washington on November 11, 12, and 13, 1954. Two nationally known speakers who will address the institute and be available as consultants are Dr. Wilma Donahue, Director, Division of Gerontology, University of Michigan, and Mr. Clark Tibbitts, Chairman, Committee on Aging and Geriatrics, U. S. Department of Health, Education, and Welfare, Washington, D. C.

The purposes of the institute are: (1) to broaden our knowledge in this field of rapidly growing importance; (2) to provide information that will enable one to plan immediate as well as long-range programs in the community; and (3) to help insure that old age will be better understood and that the later years may be made economically more secure as well as satisfying and productive.

Registration fee is 5 dollars for the 3-day period. A 1-day registration fee of 3 dollars is available for those who can attend only the first day, which will be an over-all survey of the field. For information, address: Office of Short Courses and Conferences, University of Washington, Seattle 5, Wash.

MARYLAND MENTAL HYGIENE BUDGET.—For the fiscal year 1956 the Department of Mental Hygiene of the State of Maryland has submitted a budget of $15,841,071 to the Department of Budget and Procurement. The new budget is 15.1% higher than the current appropriation of $13,762,468 and represents the largest request from any of the 40 state agencies. The bulk of the increase requested is for the 4 state hospitals and the Rosewood State Training School, the latter asking for the largest increase, namely 22.3%.

THE CHILDREN'S VILLAGE, DOBBS FERRY, N. Y.—The Children's Village is a residential treatment school for disturbed and delinquent boys, under Joseph F. Phelan, Jr., newly appointed administrator of the village, with accommodation for some 300 residents. Mr. Phelan, a graduate of Manhattan College, New York, has a Masters degree in psychiatric social work from the National Catholic School of Social Service of the Catholic University of America. He is a member of the American Association of Social Workers, the National Conference of Social Work, the National Probation and Parole Association of Training Schools and Juvenile Agencies.

Dr. John Briggs, formerly with the Wisconsin School for Boys, serves the Village as Clinical Director in charge of program. Town House, the New York after-care unit of Children's Village, is directed by Mr. Walter E. Logan, formerly associated with the Children's Center of the New York Department of Welfare.

THE ASTOR HOME FOR CHILDREN.—Dr. Joseph J. Reidy has been appointed medical director of the Astor Home, a residential treatment center at Rhinebeck, N. Y., for boys with psychiatric problems. Dr. Reidy assumed his responsibilities July 1, 1954.

The Astor Home, which functions as one of the 3 pilot projects under the auspices of the New York State Mental Health Commission, opened in January 1953. It accommodates 27 patients and is in process of expansion. Completion of a new wing is expected early in 1955.

INFANTILE PARALYSIS FELLOWSHIPS.—The National Foundation for Infantile Paralysis announces the availability of a limited number of fellowships to psychiatrists interested in the emotional problems of the physically handicapped, particularly of the poliomyelitis patient with respiratory difficulties.

Physicians who are U. S. citizens (or applicants for citizenship) and have completed 2 years of graduate training in psychiatry, acceptable to the American Board of Psychiatry and Neurology, are eligible for fellowships.

Selection of candidates is made on competitive basis by the National Foundation's clinical fellowship committee. Appointments will be for one year but may be extended upon recommendation of the committee. Stipends range from $3,600 to $7,000 a year. Applications received by December 1 will be considered in February; if received by March 1, in May; if received by September 1, applications will be reviewed in November.

For further information address The National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

PREVENTION OF SUICIDE

Half an hour ago someone in the United States committed suicide. Another has done so as these words are read; the average is a suicide every 30 minutes. These two persons are dead, and no further follow-up can help them. They have failed society, and society has failed them. But in the same half hour another 20 persons have attempted suicide. Now their stomachs are being emptied, wounds are being repaired, bullets extracted. These patients will be dismissed in the hope that they will never return. Some, however, will attempt suicide again and fail again; others will be among the yearly 22,000 persons who kill themselves in the United States. That number, incidentally, is almost exactly the number of American soldiers killed in Korea in three years of war. It behooves physicians, both professionally and as citizens, to learn how to help persons who might commit suicide.

—Herbert Bauer, M. D.,
California Medicine, Dec. 1953.
Quoted from *United States Armed Forces Medical Journal*, June 1954.

BOOK REVIEWS

PSYCHOLOGY AND ALCHEMY. VOLUME 12 OF THE COLLECTED WORKS OF C. G. JUNG. Translated by *R. F. C. Hull.* (New York: Bollingen Series XX, Pantheon Books, 1953. Price: $5.00.)

This is the first volume to be published in an 18-volume English edition of *The Collected Works of C. G. Jung.* It is the first English translation of *Psychologie und Alchemie* originally published in 1944. Other volumes of the collected works published to date (July 1954) include: *Two Essays on Analytical Psychology* (Volume 7) and *The Practice of Psychotherapy* (Volume 16).

Psychology and Alchemy is a major work of the author's later years. Its subject matter represents Jung's great interest in mythological, religious, and alchemical symbolism and their relationship to depth psychology. It is a difficult book for the average scientifically-trained doctor, delving as it does into obscure medieval alchemical treatises and ancient Gnostic doctrines. A previous knowledge of Jung's psychological theories is assumed, and without this knowledge much of the book may be incomprehensible.

The central theme is the alchemical opus and its correspondence to the course of events experienced in a deep psychological analysis. This correspondence is illustrated by a series of dreams from a patient undergoing psychotherapy. These dreams often showed a remarkable similarity to the imagery used by the alchemists in describing the procedure for the transformation of matter. It is Jung's view that the conscientious alchemists—leaving out the quacks and charlatans—in attempting to transform base matter into gold, the elixir of life, or the philosopher's stone, were actually projecting into matter their own unconscious process of personality transformation. In other words the psychic process of transformation or sublimation of primitive, infantile personality traits was seen as a chemical process and the alchemist attempted to transform in his retort an original "black substance" (*nigredo* —often filth or feces) into something of supreme value. Jung has this to say:

"The real nature of matter was unknown to the alchemist; he knew it only in units. Inasmuch as he tried to explore it he projected the unconscious into the darkness of matter in order to illuminate it. In order to explain the mystery of matter he projected yet another mystery—namely his own unknown psychic background—into what was to be explained. . . . This procedure was not, of course, intentional; it was an involuntary occurrence.

"Strictly speaking, projection is never made; it happens, it is simply there. In the darkness of anything external to me I find, without recognizing it as such, an interior or psychic life that is my own. . . . While working on his chemical experiments the operator had certain psychic experiences which appeared to him as the particular behavior of the chemical process. Since it was a question of projection, he was naturally unconscious of the fact that the experience had nothing to do with matter itself. . . . He experienced his projection as a property of matter but what he was in reality experiencing was his own unconscious."

The implications of this viewpoint are considerable. If the parallels between the alchemical transformation process and modern dream symbolism are valid, they mean that there is an inherent unconscious drive towards personality development with the goal symbolized by the elixir of life or the perfect, incorruptible substance. This process could then be considered an archetypal pattern of human development. Awareness of this drive towards transformation within himself could be of considerable assistance to the patient who is struggling with his own primitive and infantile traits. These latter dark and unpleasant aspects of personality are considered by Jung to correspond to the *nigredo* or *massa confusa* which was the raw material the alchemists attempted to transform.

The transformation process is also a kind of redemption of inferior matter, and the alchemists considered it in this light. They alluded to the analogy of Christ's redemption of human sins in describing their work. However, their attitude was fundamentally heretical because the individual alchemist took upon himself the task of redemption, whereas the church maintained that Christ had already accomplished this task for all mankind and that every believer could share the fruits of His redemption by means of faith. The alchemists thus represent the beginning of a new step in the development of human consciousness, namely, the awareness that redemption or development of personality is not automatically accomplished by faith in a divine figure but is a task requiring arduous conscious effort. It is to this task—in projected form—that many sincere alchemists devoted a lifetime of work.

Jung has found that showing patients the similarities between their dreams and alchemical or religious symbolism has definite therapeutic effect. This so-called method of amplification makes the patient aware, by means of symbolical parallels, that his problems are not unique but rather are basically the problems of all humanity. This procedure often frees the neurotic from his self-imposed seclusion and strengthens his efforts to bring about his own inner transformation.

Although this is a difficult book, the reviewer believes it is a very important one. Jung has opened up a totally new field for psychological exploration. As often happens to a pioneer, adequate recognition of his accomplishment may be posthumous.

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MEDICAL PUBLIC RELATIONS. By *Edgar A. Schuler, Ph. D., Robert J. Mowitz, Ph.D., and Albert J. Mayer, Ph.D.*, (Detroit: Wayne University, 1952.)

Wayne University, through the authors, the Academy of Medicine of Toledo and Lucas County, Ohio, and the Health Information Foundation collaborated in the study of medical public relations which is the basis of this report. The Academy of Medicine had been aware of public relations problems for some years before the specific effort that gave rise to the study, as is indicated by a historical introductory chapter. It had, apparently under the stimulus of a commercial firm which threatened to fill the need, established a Service Bureau which was designed to answer calls and locate physicians as well as route emergency calls to it. This Bureau also operated under contract with the City of Toledo to route calls for service to the medically indigent of the community.

In 1946 the leading newspaper of Toledo ran a series of derogatory articles on the medical services in the area, complaining of the physicians' opposition to compulsory health insurance, an active political issue at the time, about alleged unethical practices, about the high cost of medical care and ending with this quote: "Whatever the people choose through their elected representatives, they cannot lose. There can be nothing but improvement over the present inhuman method of taking care of the ill." This series, combined with certain "internal problems" of the profession incident to the return of physicians who had previously been in the Army, and the movement with the A.M.A. to combat socialization of medicine, led the Academy to inaugurate a more definite public relations policy. Two clear steps were taken: first the handling of complaints about medical care was revised within the Academy; and second, a newspaper advertising campaign was launched. The discussion of the first is interesting but not very enlightening, since records apparently were inadequately kept. No case studies of complaints are given. Except for what appears to have been a reasonably satisfactory administrative mechanism, there is little to be learned about this step.

The advertising campaign was based primarily on paid newspaper ads, facsimiles of which are reproduced in the appendix. These were directed at 3 major objectives: first, to acquaint the public with the fact that a physician was always available through calling the Academy; second, that it was a good thing to have a family physician; and finally a "veiled hint" that the Academy was willing to accept and deal with complaints. Unfortunately, no protest was done so that the study can and does not attempt to say what this campaign really did. It studies the attitudes of only three groups: physicians (54), community leaders (50 of whom 12 were physicians), and the public (554 heads of families). Each of these groups is reported by a different member of the research team, and in each case interview schedules were different, so that little can be learned from comparing the group. The description of results in the public survey is burdened with a very large number of tables that are not very informative.

Almost all physicians felt the advertising project had been a good move, though 39% could not recall certainly having seen any of the series in the paper. They felt the best idea in the project was the reassurance of the public that a physician could be obtained. Most physicians favored a sliding scale of fees dependent on income but felt the principle abused to some extent. Shortages of hospital beds and personnel were considered the major deterrents to good medical practice. Complaints were considered most likely to arise on the basis of fees, again partly because some physicians were likely to be "pigs."

The community leader group, with the large majorities that are characteristic of most of the answers in this whole study, felt that medical care was of high quality. Criticisms were directed primarily at a presumably small group of "lemons" who violate the general standards of the profession. There were stories of unnecessary operations, pass diagnosis and treatment, and unfair billing. Some felt that itemized bills would aid the public in understanding why they were high. There was the allegation that medicine operates, and to some extent must operate, as a business, but it does so with special ways of concealing or adapting to the competition within it. The advertising campaign appears to have had little effect, though a high percentage knew about the emergency service and approved it. Compulsory health insurance was obviously much on everyone's mind and those who did not recall the advertising campaign usually assumed that it was aimed at its defeat.

The public sample appears to have been well selected and fairly representative, though the results seem rather meager in comparison with the amount of work done. Half of the population appeared to know that emergency medical service could be obtained through the Service Bureau of the Academy, though only 8% had learned of it through the advertising, the rest from physicians, relatives, or friends. The public was found to be unable to evaluate its medical care; 60% of respondents had no opinion on the matter. Similarly a high percentage of the respondents left it to the doctors to improve medical care; they seemed to feel little responsibility in this direction. A "symptoms approach" technique led to the conclusion that 57% of the population were receiving "higher level" medical care, the rest, less adequate care. The highest income group had the better medical care and fewer symptoms, the middle income group being more like the highest than the lowest in this respect. Ninety-two percent of all the samples had family physicians. There was little complaint about the high cost of medical care; this may be related to the fact that 84% were carrying hospital insurance, 60% surgical costs insurance, and 22% insurance against physicians fees for other than surgery. There were some complaints that insurance payment of surgical fees simply resulted in higher fees so the net to the patient was not actually realized. The authors

conclude that the public is very badly informed on the "medical facts of life."

While the findings of the study are interesting, they are of little scientific value aside from being a description of the situation at a particular time. There is nothing to compare them with. The construction of questionnaires to better record the spread of opinion is not discussed; perhaps the public information is actually so poor that it is a polar as the study would indicate. The book leaves one with a feeling that the sociologists and social anthropologists who executed this research somehow missed the emotional aura surrounding medicine, or if they felt it, they did not succeed in transmitting their consciousness of it to the reader. It is my impression that there are more lively feelings held about medicine by the public than are pictured in this book.

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THE CHILD'S CONCEPTION OF NUMBER. By *Jean Piaget*. (New York: Humanities Press, 1952. Price: $5.00.)

This is a translation from the French of a book published in 1941. It is one of a series by Piaget in which he has analysed the development of various verbal and conceptual aspects of the child's thought. In this book he attempts to trace the development of the operations which give rise to number, continuous quantities, space, time and speed. The basic method is the same here as in his other studies, namely the use of free conversation with the child. This conversation is recorded in detail and abundant samples are used to illustrate the theory developed. The free conversation is stimulated by questions and by the use of concrete objects. Piaget is able to find, in this analysis, stages in the development of concepts relating to number. Such analysis into stages is not as valuable as the total developmental picture which tends to be obscured by the sharp delineation of stages.

For the reader who is used to precise controlled experimentation with results tabulated so that it is possible to assess how many subjects were used, what conditions they were subjected to, and what exactly was measured and what the quantitative results were, the more descriptive account of Piaget's work is rather confusing. It is impossible to tell exactly how many children of what ages were used, or exactly what was done. However, when the reader stops looking for tables of results he begins to see something of the importance of the descriptive account of the development of the child's thought.

Another difficulty arises which may be even more serious. This difficulty is inherent in the attempt to get a longitudinal picture of development by studying children of different ages instead of using a true longitudinal method in which the same children are observed over a period of time to establish the changes as they occur and the situations which produce these changes. But perhaps we should not ask for too much. Piaget has given us a very helpful preliminary analysis of the development of number concepts. It remains now for someone else to take the next step in filling in the developmental picture with a more adequate longitudinal study.

This book as one of the series by the same author is an important contribution to our knowledge of intellectual development of children.

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PSYCHIATRY AND MILITARY MANPOWER POLICY. By *Eli Ginzberg, John L. Herma, and Sol W. Ginsburg, M. D.* (New York: King's Crown Press, Columbia University, 1953. Price: $2.00.)

This 66-page monograph is an analysis of the replies of a group of 35 representative psychiatrists, who had been on active duty during World War II, to a questionnaire concerning their experiences and later reflections on those experiences. The questions concerned the meaning of the screening rejection figures, the causes of breakdown, and the comparability of military service with civilian life. The objectives of the project were to identify and evaluate the major areas in which significant wastes of manpower occur, to discover the factors responsible for these wastes, and to make recommendations that can reduce or eliminate them.

The 5 chapters—"Psychiatry and Military Manpower," "What Do the Figures Mean?" "Why Did Men Break?" "Adjustment in Military and Civilian Life," "How Can Manpower Be Saved?" "The Ineffective Soldier"—consist of those portions of the psychiatrists' replies, relative to the topic of the chapter, and a discussion by the authors. The authors believe that "this amalgam of facts, theories and opinions is a contribution to an extremely important but obscure facet of our national experience."

The conclusions drawn by the psychiatrists from their experience were: (1) that because it is impossible to define potential breakdown, screening should aim at rejecting only those with the most obvious evidence of emotional disturbance; (2) caution should be taken in the use of statistical data concerning screening and separation for psychiatric reasons during World War II, because of the radical changes in personnel policies and administrative procedures; and (3) that there had been a misapplication of clinical concepts to matters of military service.

While this monograph is only a preliminary study it should be read by psychiatrists and others who may be concerned with military manpower.

JOSEPH S. SKOBBA, M. D.,
Atlanta, Georgia.

CURRENT THERAPY—1954. Edited by *Howard F. Conn, M. D.* (Philadelphia: W. B. Saunders, 1954.)

This is now a well-established yearly volume of a reference book of therapy. Where many new remedies are being introduced all the time, and where

disadvantages and undesirable features are not at first apparent, it is only by careful and constant revision that a survey of this kind can be counted as valuable. This has been accomplished very well in this latest edition, and it constitutes a valuable guide to the treatment of all the usual diseases and situations, and also many of the less common and more complicated illnesses. The reader will find alternative opinions on treatment of the same condition which will make it of real interest to choose the plan most suited to his particular problem.

Books of this type have, of course, been attempted previously, but Dr. Conn's immense effort has been rewarded, one can say, by success.

TREVOR OWEN, M. D.,
University of Toronto.

DIE EXEKUTION DES TYPUS. By *Prof. Dr. W. Wagner.* (Stuttgart: George Thieme Verlag, 1952.)

This work ventures some opinions on cultural psychopathology, *i.e.*, the psychological illnesses that affect the mob, the crowd, and at times an entire nation. Essentially, however, it is an apologetic exposition to account for the Nazism of the Germans, and for their irrational, mad cruelties. As such it is a brave attempt which sadly fails in its aim. The author unwittingly obfuscates and confuses the theories advanced by such as Oswald Spengler and Wilhelm Diethey, on the decline of civilizations, with the dynamics of crowd madness.

Dr. Wagner postulates that the entire world, and not Germany alone, is sick. But he expounds his thesis only within the framework of German history and experience. The pathological symptoms he describes are particular to the Germans and not to the English, the French, or the Americans. Thus one of the evils the author dwells on is the disparagement of the individual and the unique, and the deification of the prototype. The common denominator, the cliche, the reified group, have taken the place of the individual and the singular. Judgments are therefore never differential, conditional, or partial but always total. Entire groups, treated as a homogeneous unit, are judged, praised or condemned, en masse. Events are not analyzed discretely but are charged to the operations of total agents, such as *the* English, *the* Catholics, *the* youth of the nation, etc. This practice encourages search for *the* guilty, and facilitates the finding of a scapegoat.

Why these evils?—according to the author, because group pressure deprives the individual of his individuality. He cannot prevail against the collective mass. "One is a party man, a Bavarian, a class-conscious proletarian, a government employee or a Soviet man, a German, a vegetarian, a nonsmoker or a Fascist, but otherwise one is nothing." And this has come about largely because of the generalizations fostered by modern science. These generalizations, these common denominators in knowledge, afford every man a ready opinion on anything and everything, but they also weaken his competence to judge, to form his own opinion. He is then readily swayed by others.

One of the most suggestive chapters in this provocative book deals with the alleged predominance of vision over the other senses in orienting and in bringing the individual into contact with his world. In the sense of the old proverb, "Seeing is believing" —even against the protest of the other senses. The predominance of vision has weakened and corrupted man's contact with his immediacy, and has distorted his judgment. The author urges that to regain our orientation we should compound our senses—"unsere fünf Sinne wieder *zusanumennehmen.*" In a similar exhortative vein the author urges that knowledge alone will not suffice to heal this ailing world. To free one's self from the overwhelming power of circumstances and relations (*Übermacht der Verhältnisse*) each must collect himself, and in his own way prove true to himself.

As an apologetic for the Nazism of the Germans, an intent not openly professed but one patent in the text, this work is naive and a total failure. It is naive in a childish way to portray the hypothetical growth of prejudice against and the ultimate extermination of gypsies (*Zigeuner*) when there is the bloody reality of the liquidation of 10 million Jews, Poles, and Russians to be accounted for. Nor is it at all convincing to lump Germany with all other nations, and to proclaim the whole world sick of one sickness.

Yet from this it must not be construed that the author is a pleader for the Nazis or that he intends to excuse and to explain away the crimes of his nation. On the contrary, he is very much in earnest and humble in the sight of the calamity that befell the Germans and the world entire. The trouble is that his thesis is misdirected and his arguments beside the point. What he treats are the *faults*, the unwisdoms of our culture, not its madnesses. He has missed the crucial point—that of "brain washing," a something to which his unfortunate people appear to have a great liability, if not a definite predilection. It is too bad the author did not include in his *Literaturauswahl* George Orwell's *Animal Farm* and *1984.*

IAGO GALDSTON,
New York City.

PARENT AND CHILD. By *Prof. James H. S. Bossard.* (Philadelphia: University of Pennsylvania, 1953. Price: $5.00.)

This admirable book by Professor Bossard is concerned primarily with the effects upon child development of parent-child-sibling interrelationships and other features of family living. To this analytic study of specific case material the author brings his wealth of sociological training, experience and insight, and his recognition of the family, within our western culture, as a changing sociological group having unique but individually varying characteristics. In an introductory chapter he places the study of human behavior in a larger context. After calling attention to major difficulties (paradoxical contrasts in human nature and man's tendency to rationalize behavior) and impediments to understanding (shortcut explanations and preoccupation with methodology), he summarizes under "proprieties in the

study of behavior" a series of basic methodological relationships: unborn characteristics and learning in relation to the development of individual and social behavior, the contribution of experimental psychology to understanding of the learning process, importance of emphasis upon the minutiae of life, life-history documents as source material, and the need for objective study of social situations.

The volume exemplifies the author's contention "that social situations can be relatively isolated, described, classified and evaluated in an orderly, inductive procedure." Successive chapters deal with the effects of many facets of family life upon the child's social development. Early chapters are concerned with more general characteristics, the interactive family unit with its various members and related kinship groups as a background for child development, distinctive features of the "small family" and "large family" systems and the importance of space as a determinant of the number and nature of interpersonal relationships. Later chapters discuss effects of a sequence of parents, of interclass marriages, overage parents, parental occupation, and presence of domestic animals.

Two chapters consider the transition from family living to later social independence, traced from early childhood visiting through such formal recognition of adulthood as the social debut. A final brief chapter gives a critical summary of current sociological theory regarding the role of the family, and, in conclusion, suggests the concept of "the point of highest returns" (in contrast to the law of diminishing returns) as a basis for determining relative values in studies of sociological questions. This criterion can be adapted for work with diverse cultural groups, and is applicable also to investigation of specific problems such as the most desirable ages for parenthood and the relative importance of differences between mates in religious or educational background.

Of special value for those who are seriously interested in the problems discussed in this volume is the documentation in each chapter of the more important aspects of its thesis. Carefully chosen and effectively presented excerpts from case history material, summaries of sociological researches under the auspices of the William T. Carter Foundation of the University of Pennsylvania, data from the United States Census showing the relative numerical importance of various household groups, accounts by university students of early experiences, and material secured through nondirected interviews, illuminate and supplement the text subject. The author index and a brief summary at the end of each chapter are aids to ready reference.

This volume will be of interest to professional workers concerned with children's social development or with evaluation of case history materials. For those engaged in the fields of child psychiatry, child guidance, social work, and family counselling, especially, it will point up important problems and furnish useful reference material.

HARRY C. STORRS, M. D.,
Letchworth Village,
Thiells, N. Y.

DIE NACHKOMMEN GEISTESKRANKER EHEPAARE. Der Einfluss endogener Elternpsychosen auf die Psychosen, Charaktere und Lebensschicksale Ihrer Kinder. (The Descendants of Psychotic Parents. The Influence of Endogenous Parental Psychoses on the Psychoses, Character and Life Destiny of Their Children.) By *Gunter Elsasser*. (Stuttgart: Georg Thieme, 1952.)

This is an extremely interesting attempt at an examination of endogenously psychotic parents and their descendants. The examination of the cases, which are described clearly and at great length, is a clinical nosological one and an examination from a biological-hereditary point of view. It is typically German and brings a lot of interesting material.

Elsasser uses not only his own cases but also the already published ones from the material of Eugen Kahn and B. Schulz. Altogether he has 134 couples of psychotic parents, 34 of them real schizophrenics and 20 manic-depressives; in 19 others the parent had a schizophrenic and a manic-depressive partner. Of the rest of 61 couples were one or more seldom two atypical psychotic partners.

The interesting result was that the psychotic children of schizophrenic parentage had exclusively schizophrenic psychoses. As to the manic-depressive psychoses the meaning of the result is somewhat more difficult. This has an explanation in the fact that both of the psychotic parents seldom showed a pure, classical disease unit. In spite of this the majority of the children of manic-depressive parents also had manic-depressive psychoses.

Parents with one schizophrenic and one manic depressive partner have about as many schizophrenic as manic-depressive children.

As to the frequency of real psychoses in children only 3%-40% of the children are really psychotic.

Of 268 psychoses of the parents, 77 had to be called atypical, endogenous psychoses. Elsasser differentiates 6 different groups of these atypical psychoses. He shows in this very precise paper that the endogenous psychoses of parents and children are the same as to symptoms or course or termination.

The author includes a chapter on psychoses of identical twins, showing that although the psychoses in each may have a different symptomatology, the so called disease units are the same in both.

The nonpsychotic children of all combinations of endogenously psychotic parents are between 55% and 85% completely normal as to temperament in the sense of Kretschmer or as to outstanding characteristic patterns.

Elsasser's book, which has in this country only the work of F. Kallmann as comparison, ends his interesting study with some chapters on body-build problems; on the question of choice of partner; and some sociological experiences in his examinations. This book must be read by all interested in good clinical psychiatry and in problems of heredity.

WILLIAM MAYER, M. D.,
New York City.

Music Therapy. Edited by *Edward Podolsky.* (New York: Philosophical Library, 1952. Price: $6.00.)

After having perused a number of books and pamphlets dealing with "music therapy," this reviewer finds that there are two types among them: those that start with the story of how David cured King Saul from his depression by playing the harp, and those that do not. The current book belongs to the first category. The frequent reference to the biblical story is supposed to illustrate the ancient origin of "music therapy."

The editor of the current volume in his own contribution lists a few popular ideas about the value of music for mental health, indulging freely in commonplace statements and unwarranted generalizations, such as the following: "Physicians throughout the world are beginning to realize that music is of definite value in keeping the mind healthy. . . ." or, "It has found that music lessens the fury of the most violent cases. . . ."

Then follow about 30 articles of unequal value, lined up without critical evaluation. Some of the contributions contain definite scientific material. Among them we may mention the articles by Altshuler, Reese, Grunewald, Pepinsky, and others. On the other hand, we also find articles ranking below scientific level, such as, that by Lawrence Walters, music therapist, entitled "How Music Produces its Effects on the Brain and Mind." The title fills the reader with high expectations: now, at last, he will be able to see the mystery uncovered as to how music is transformed into brain function and how a morbid mental reaction may turn into a wholesome one. But alas, he learns instead that: "Music very definitely [!] produces measurable effects on the brain and mind. It is quite logical [!] that when measurable results are produced on the brain, the mind is also in some way [!] influenced . . ." Walters then theorizes that "The Id, otherwise oblivious to the world [!], heeds music. The Ego, which is threatened by reality [!] does not remain immune totally for in the realm of music there are no sharp conflicts, and thus music is acceptable to the Ego. The Superego, too, is accessible as far as music is concerned because, unlike the sphere of thought and speech, music creates no feeling of guilt. . . ."

Podolsky's collection contains a large quantity of trivialities of this type, interspersed with products of genuine scientific labor. We find a particularly high number of psychiatrically contestable statements in chapters in which the impression is made that we can now use music in form of a doctor's prescription in a variety of nervous and mental conditions. The headings of these chapters are: "Music Therapy in Depression," "Music Therapy for Emotional Disturbances," "Music Therapy in Acute Grief," "A Musical Program for Emotional High Blood Pressure," and the like. Most of these articles are, significantly, written by nonphysicians.

When psychiatrists, like Altshuler, state that "in the future the musician is destined to play a very important role in the care and treatment of nervous and mental diseases as well as in mental hygiene," we can concur with this view only under one condition: that those whose responsibility it is to care for and treat nervous and mental disease give up all empty rhapsodizing on the theme of "music therapy" and cease encouraging musicians to enter a therapeutic field for which they have not as yet created a workable basis; but that, instead, they buckle down to the task of conducting assiduous laboratory experiments so that such a basis may, one day, be established. It is good to know that in scientific laboratories and therapeutic institutions of the world promising work in this respect is going on right now.

This reviewer has repeatedly emphasized that the term music therapy must be properly defined to serve as a specific symbol of communication among scientists. Music can be used *in* therapy, just as painting, basket-weaving, or ball-playing are used; it can be applied with particular success in its occupational, recreational, and inspirational aspects. It is unfortunate that many of the studies on music therapy conducted so far have been done by uncritical workers. This is the reason why, despite its ancient origin, music therapy as an independent curative approach has remained undeveloped. The findings of uncritical observers are being reiterated, reprinted, and used as evidence by uncritical writers. Thus the myth of music therapy is kept alive.

It is time that the Saul-and-David literature be discontinued. When serious students of music and of the mind will find the answer to the baffling question as to how music *really* affects the human mind, then—and only then—we shall begin to speak of therapeutic applications of music. Meanwhile, this reviewer cannot but repeat what he has stated on another occasion: "The task of the psychiatrists should be (a) to discourage wasteful dilletantism; (b) to coordinate the efforts of bona fide scientists which may, one day, lead to the development of a special form of psychotherapy using music as its tool; and (c) to subordinate within the therapeutic planning the musician's activity to that of the psychiatrist. Until then—we will require from the professional groups as well as from the public a great deal of patience with the slow progress of music research. The world has always had plenty of time to wait for a great scientific contribution; it is with trifles that it is impatient."

From this point of view, Podolsky's book is—premature.

Emil A. Gutheil, M. D.,
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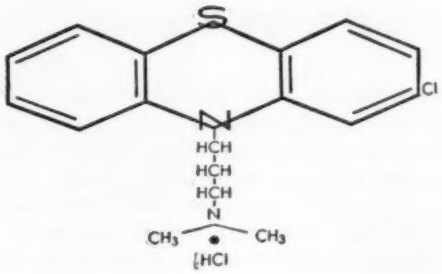

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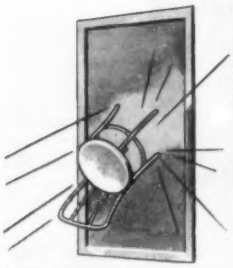

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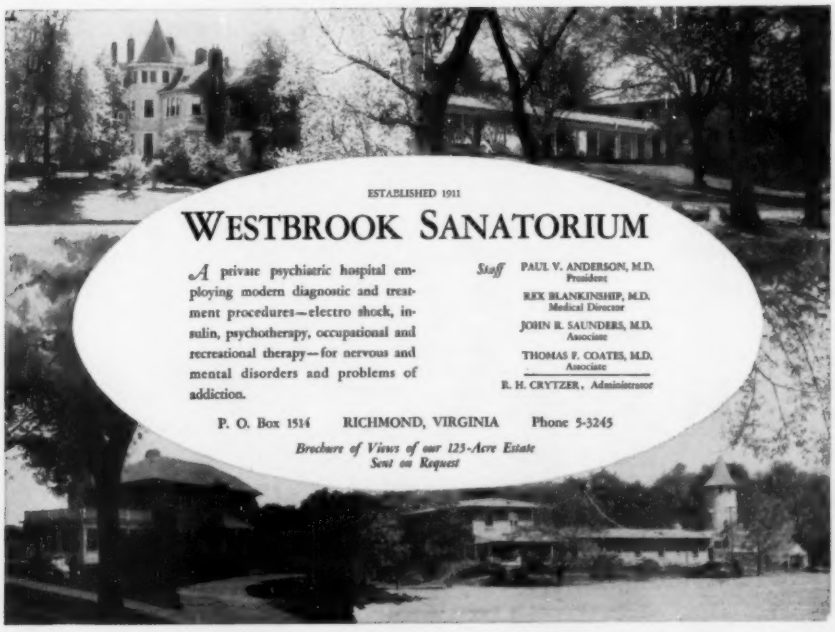

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